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ABSTRACT

This special issue of the "Family Life Educator" features a planning document on adolescent pregnancy prevention designed to assist communities throughout the United States in translating the National Research Council's recommendations and strategies from the "Risking the Future" study into steps for future action. An introduction provides a general overview of the problem and of strategies for attacking it, and explains the genesis and purpose of the document. This is followed by three sections with the following headings: (1) Helping Teens Wait: Abstinence Education; (2) When Teens Don't Wait: Encouraging Contraception; and (3) Reasons to Wait: Enhancing Life Options. A brief concluding summary encourages communities to use the strategies and action steps included in the document in their efforts to meet the challenge of preventing adolescent pregnancy. The summary also enumerates the key factors that have been found to be present in successful programs: early intervention, accessibility and acceptability, continuity of services over an extended period of time, targeting of strategies to meet the varying needs of young people, multipronged and integrated approaches that incorporate a variety of concurrent strategies within a comprehensive community-wide plan, and broad-based commitment from major community institutions. (NB)

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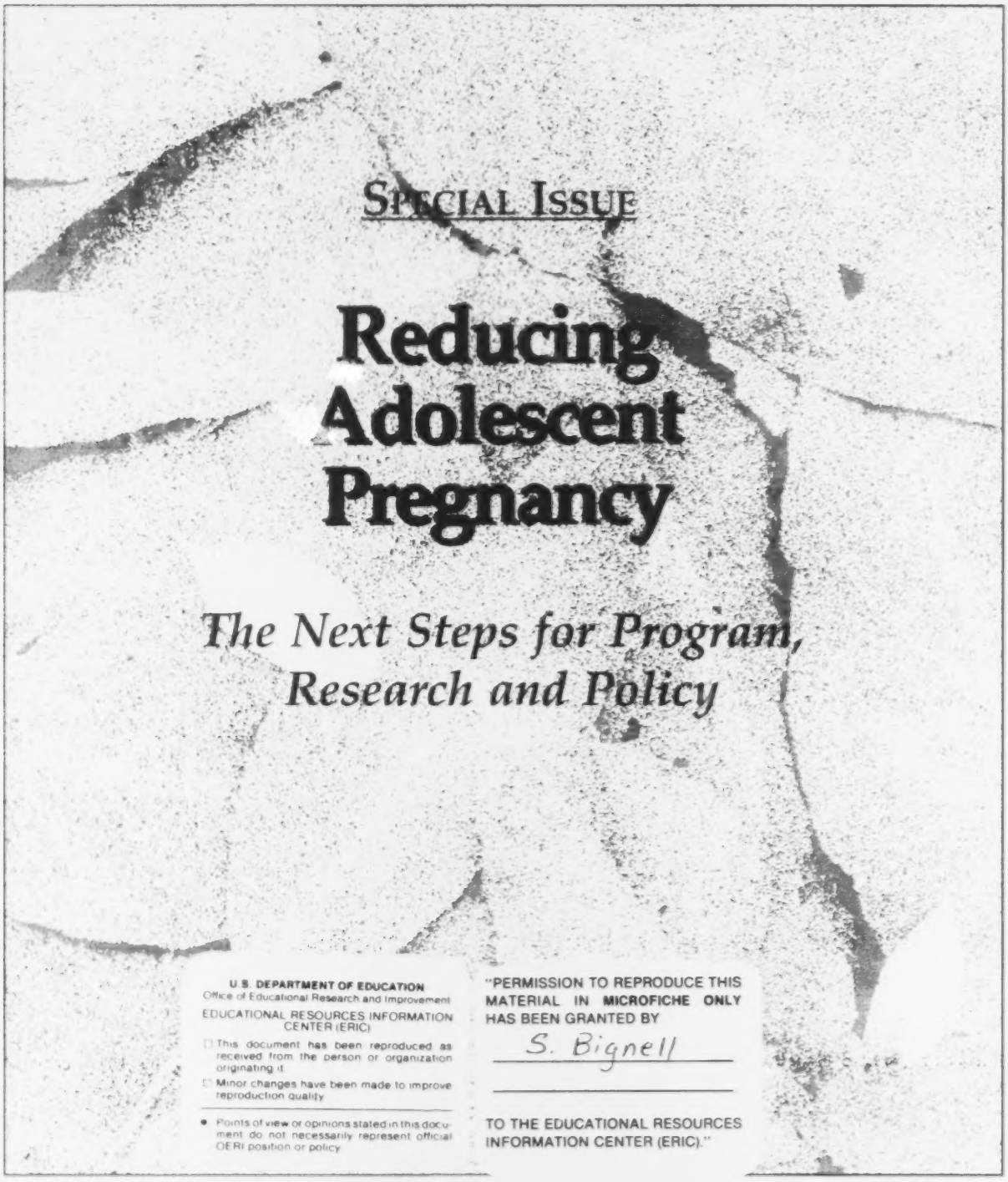

SPECIAL ISSUE

Reducing Adolescent Pregnancy

The Next Steps for Program, Research and Policy

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Family life education should provide individuals with adequate and accurate knowledge of family life in its physical, psychological, social and moral dimensions, enhance self-esteem, encourage self-understanding, increase skills in decision making and communication, clarify personal values, promote respect for family values and the values of others, encourage communication between parents and their children, and promote fulfilling, healthy and responsible behavior.

Formal family life education courses should be designed cooperatively with representative parents, educators, community professionals, clergy and youth and should include various points of view, values and religious beliefs.

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Special Issue

Reducing Adolescent Pregnancy

The Next Steps for Program, Research and Policy

by Claire Brindis, DrPH

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We're pleased to begin the 9th volume year of *Family Life Educator* with this special issue devoted to adolescent pregnancy prevention. When ETR Associates and the Center for Reproductive Health Policy Research proposed that *Family Life Educator* publish the planning document from their national convener group's collaboration on the prestigious National Research Council's *Risking the Future* study, we quickly accepted. Few issues today impact so many young people—and the adults who work with them—as teen pregnancy. Few magazines reach so many of the professionals whose work has the potential to impact the multilevel issues involved in reducing the high teenage pregnancy rate. Finally, the purpose of the planning document is to assist communities throughout the United States translate the NRC recommendations and strategies into steps for future action. Few publications have a readership so well suited to formulate, refine, implement and evaluate the necessary programs, research and policy to fulfill the agenda developed by the National Research Council's expert panel.

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Introduction

The 1980s saw a dramatic increase in policies and programs to help delay teenage pregnancies and reduce the adverse consequences of early childbearing. At the same time, there was little understanding or consensus about which policies were most effective. From federal efforts to those of states, communities and private foundations, a key question remained: What works?

In 1985, the National Research Council (NRC), which draws its members from the National Academy of Sciences, the National Academy of Engineering and the Institute of Medicine, appointed a 15-member expert interdisciplinary panel (the Panel on Adolescent Pregnancy and Childbearing) to study the issues and document how various interventions impact the problem—whom they affect, under what circumstances and with what intended (or unintended) effects. In 1987 the NRC released the results of the study in 3 volumes: *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing.*

The report reflected three major tasks: (1) to assemble, integrate and assess data on trends in teenage sexual and fertility behavior; (2) to review and synthesize research on the antecedents and consequences of early pregnancy and childbearing; and (3) to review alternative, preventive and ameliorative policies and programs. *Risking the Future* helped establish the "state of the state" of knowledge and understanding in the field of adolescent pregnancy. It also helped establish a broad mandate for important future directions in the arenas of service delivery, research and policy formulation.

The report provided a comprehensive review of previous efforts and strategies used in resolving the issues surrounding adolescent pregnancy and parenting. It focused on the full continuum of efforts, from primary pregnancy prevention through the treatment and amelioration of the impact of too-early childbearing. The panel formulated a series of goals and

recommended the most promising program areas and strategies by which these might be accomplished.

The goals that directly relate to adolescent pregnancy prevention are to reduce the rate and incidence of unintended pregnancy among adolescents, especially among school-age teenagers; to provide alternatives to adolescent childbearing and parenting; and to promote positive social, economic, health and developmental outcomes for adolescent parents and their children. Within the scope of these 3 broad goals, specific recommendations and strategies were proposed for further action.

The NRC report helps document that while there exists an extensive body of research and literature that describes efforts aimed at the adolescent who faces an unintended pregnancy, the more general field of adolescent pregnancy prevention is at a relatively early stage of development. This is partly a result of the wide array of options in which an intervention can take place and partly because we have had far fewer attempts to evaluate adolescent pregnancy prevention efforts.

In the area of primary adolescent pregnancy prevention, the NRC panel suggested 3 goals: Delay the onset of sexual activity among adolescents; encourage sexually active teens to use contraceptives; find ways to enhance the life options of adolescents for whom pregnancy might appear to be a positive alternative.

Although the recommendations are critical to directing policymakers, health educators and health providers to the "next steps for the next decade," it was not the role nor intent of the NRC panel to present these recommendations as a specific action plan for program formulation, refinement, implementation and evaluation.

National Convener Group

To help translate these major policy guidelines into an action plan, ETR Associates, a health education organization in Santa Cruz, California, and the Center for Reproductive Health Policy Research, an independent policy research institute at the University of California, San Francisco, received private foundation funding from the General Service Foundation and the William and Flora Hewlett Foundation to convene a special invitational working group comprised of key organizations and decision makers across the country. (See the inside back cover for a list of these organizations.)

Selection of convener participants was based on their recognized leadership role in the area of adolescent pregnancy prevention and/or in the area of youth development. The challenge to this group was to identify specific strategies that could be instituted to enhance implementation of the NRC panel's recommendations.

This document is... to assist communities throughout the United States to translate the NRC recommendations and strategies into steps for action.

Three important questions emerged: (1) What implementation strategies could be undertaken at the local, state and national levels? (2) What specific program, policy and funding activities are critical to full implementation of the recommendations? (3) Who should be involved in implementing these strategies and activities?

Participants in the convener group conducted interviews, completed questionnaires and held meetings to develop specific implementation activities that would help the NRC recommendations become reality for young people. Conveners also identified the key players and their roles in implementing the NRC recommendations and strategies.

This document is a result of these efforts. Its purpose is to assist communities throughout the United States to translate the NRC recommendations and strategies into steps for action. Each of the 3 recommendations is summarized, and specific activities are suggested to help

communities implement the strategies necessary to delay childbearing among adolescents.

Convener group members represent both the public and private sector, display a multidisciplinary background and offer a blend of service agency and advocacy perspectives. Thus, they could be considered a viable model for the efforts that are needed in communities throughout the country. Bringing together major interest groups who work with youth to develop a community-wide adolescent pregnancy prevention strategy is of paramount importance.

Adolescent pregnancy prevention is extremely complex. It requires more than the categorical responses and prescriptive solutions of the past. The issue must be examined within a larger societal context, one that requires the involvement and commitment of an extensive network of individuals and organizations working in collaboration at the local, state and national levels.

The Cast of Players

The "cast of players" should include school teachers and administrators; community-based organizations working with youth; funders; and policymakers in the legislative, health, education and social service arenas. These individuals, as well as the state and national organizations to which they belong, can furnish the backbone for efforts to organize a broad-based and comprehensive program aimed at reducing the incidence of adolescent pregnancy.

For those communities that have not developed a community-wide adolescent pregnancy prevention strategy, the implementation or action steps that follow may provide guidance on the available options. Other communities may have already initiated a specific focus on adolescent pregnancy prevention and may be actively involved in some of the activities. For those communities, the intent of this report is to reinforce their efforts and to suggest a variety of ways that efforts can be expanded.

Some of the following suggestions also have relevance for those concerned with broader health and social issues that impact adolescents, such as reducing risk-taking behaviors and preventing school dropout. Efforts to reduce adolescent pregnancy are not isolated from other efforts to help youth. These efforts should be considered as part of an overall strategy on adolescent health.

As previously noted, resolving the dilemma of adolescent pregnancy requires efforts that integrate a variety of strategies. Categorical approaches to the problem are not responsive enough to impact at-risk adolescents. A philosophical underpinning of this planning document is the need for comprehensive, developmentally appropriate, community-wide and integrated efforts aimed at helping communities deal effectively with the challenge of reducing too-early childbearing. This philosophical tenet is woven into each of the following recommendations.

Some of the following suggestions respond to the necessity of changes at the system level. Others can be more readily incorporated as part of daily program activities. The strategies are directed at decision makers at a variety of levels, from direct service providers and program managers to other decision makers and policymakers.

The school's role is critical, because young people—unless they are dropouts—spend more time there than anywhere else except home.

Direct service providers are those professionals actively engaged in providing services to youth—whether within a health or social services program or youth-serving agency. A policymaker might be a state legislator, an elected or appointed official or someone from the department of health or education who is in position to make important funding decisions.

Many young people receive supportive care from a number of nurturing individuals—from family members to informal community leaders—who are deeply committed to the youth of their communities. We encourage providers and other professionals to explore ways in which parents and families can be mobilized to contribute to these efforts.

Strategies in the Classroom

Prevention programs fall primarily into three categories: health, education and social welfare. Relatively few comprehensive programs integrate services from all three. Although some of these efforts are directed at the economically disadvantaged, some—such as programs in the educational system—reach all adolescents. The school's role is critical, because young people—unless they are dropouts—spend more time there than anywhere else except home.

Thus, a primary strategy for pregnancy prevention begins in the classroom. Educators can help teens build academic skills and provide opportunities for increasing self-esteem and self-sufficiency. These components should complement programs in family life education, family planning, parent-child communication, and STD and AIDS education.

Postponing pregnancy is the shared responsibility of families, schools, churches, businesses and our government—but these groups face many barriers in providing care for those most in need of their assistance. The lack of viable links between agencies and the varying levels of community awareness impact adolescent pregnancy prevention efforts.

Although many adolescents need health, education and social welfare services, barriers to participation keep many of them from getting the help they require. Not all programs are available throughout the states. Even where services are available, those in greatest need may not know of a program's existence or may not qualify to receive care. In many communities, adolescents face increasingly long waiting lists. On the local level, it is not unusual for agencies to operate in a parallel manner, rather than being coordinated and linked. Agencies continue to operate in isolation from each other except where individuals have developed informal contacts. Often state agencies face a challenge in coordinating efforts within the agencies themselves.

Comprehensive approaches, in which the health, social and educational needs of teenagers are all addressed within a coordinated system of care, are considered effective and promising. However, more evaluation is needed to document the effects of these programs. Some people believe that comprehensive programs respond best to teenagers' multiple and simultaneous needs. Others favor specially targeted or focused approaches, such as family planning services directed at teenagers. To be successful, both comprehensive and single-focus programs require long-term community commitment, adequate funding, significant and sustained outreach, contact and follow-up, as well as access and willing involvement by at-risk adolescents.

In terms of funding, models of partnerships between the private and public sectors to support provision of human services are slowly emerging.

To develop a coordinated set of services—health, education, employment training and social welfare—a variety of local, state and federal funding sources must be pulled together. At the federal level alone there are at least 9 potential sources of support for at-risk adolescents, including Medicaid, Maternal and Child Health block grants, Preventive Health and Health Services block grants, Adolescent Family Life Program, Title X Family Planning, Social Services block grants, Community Services block grants, Chapter Two of the Education Consolidation and Improvement Act of 1981,

and the Job Training Partnership Act (Kimmich, 1985).

The activities of many public and private groups (schools, health clinics, churches, businesses, foundations, the judiciary, law enforcement agencies and private community agencies) must also be carefully organized and coordinated if necessary services are to be administered effectively. State officials play a central role in facilitating the necessary coordination among public programs. State policies regarding education, health, job training and social services directly influence the availability and effectiveness of services for youth at risk.

At this time state and federal funding is limited to the most basic governmental services. As a direct result, most social service, health and education programs will need to target adolescents whose social, economic and educational profile places them at the greatest risk of premature parenthood. Special targeting may be especially important for programs that adopt intensive case management approaches, where caseload must be limited to assure program effectiveness. In terms of funding, models of partnerships between the private and public sectors to support provision of human services are slowly emerging. The role of private foundations in matching governmental sources for developing innovative responses to social issues is increasing.

Public and Private Partnerships

Efforts to develop adolescent pregnancy prevention programs will also greatly benefit from public and private partnerships, both in the development of innovative service delivery models and in their ongoing funding. Businesses will benefit from working with schools to assure a well-trained labor pool. And society will benefit from a reduction of the number of pregnant and parenting teenagers dependent on social programs and an increase in the number of economically self-sufficient young people.

Policymakers also need to explore ways to increase life options for youths, so the motivation to delay childbearing is increased. This means supporting programs that provide young people with the nurturing and attention they need to believe that positive decisions can make a difference in their lives.

Since the release of the NRC's report, the issue of adolescent pregnancy has continued to be recognized as an important policy issue for the public. In the 1980s, more than half the states created initiatives originating in either the state legislature, task forces appointed by the governor or an interagency committee drawn from, for example, the state health, education and social services departments (Kenney and Somberg, 1989).

Pregnancy, crack cocaine use and the increasing prevalence of STDs among teens have contributed to increasing concern about the status of adolescent health.

Many of these initiatives focused on services for pregnant or parenting teenagers. Those that focus on prevention tend to emphasize the teaching of abstinence, expansion of FLE programs or efforts to improve the life options of young people. While these initiatives are important components of a comprehensive array of strategies for young people, far fewer states have committed themselves to supporting accessible contraceptive care for adolescents—the only strategy documented to show a direct impact on adolescent pregnancy.

In addition to the societal focus on the issue of adolescent pregnancy and pregnancy prevention, emerging social and health problems have created special challenges. Many of these problems have a relationship to the issue of adolescent pregnancy, because among many youth there appears to be a clustering of risk-taking behaviors (Dryfoos, 1990). Pregnancy, crack cocaine use and the increasing preva-

lence of STDs among teens have contributed to increasing concern about the status of adolescent health. In addition, the number of young people who are being raised in poverty has increased over the past decade.

Much youth mortality and morbidity is the result of social factors and risk-taking behaviors. Efforts are underway to document even more extensively the magnitude of youth health and social problems. These include a *Chart Book on Adolescent Health* being published by the federal Maternal and Child Health branch, a special study on adolescent health by the Office of Technology Assessment and a special series of resource materials on adolescent health being developed by the American Medical Association.

In addition to efforts to gain a greater understanding of the incidence and prevalence of health problems among youth, a number of second-generation intervention efforts are beginning to develop. These efforts share a common philosophy: Comprehensive and integrated services that incorporate health, counseling, educational, employment and recreational activities may be a better way to meet the diverse needs of youth. Thus, sites which provide a variety of services, often combined with case management services, are beginning to be developed in the field.

Two Prevention Approaches

New efforts are also being initiated to unite businesses and others in the private sector with adolescents as a means of investing in America's business future. These approaches, built on the emerging themes in the field of adolescent pregnancy prevention, have clustered around two concepts: (1) increasing the life options available to young people and (2) increasing the capacity of young people to make decisions—particularly in the area of sexuality.

Increased capacity implies having the knowledge and skills to prevent unintended childbearing, including sex and family life education, support for abstinence, access to birth control if sexually active—and abortion services as a backup for contraceptive failure. Life option interventions provide the personal motivation for postponing pregnancy, the skills necessary for completing an education and entering the labor force, and alternatives to early motherhood. Strategies include school enhancement, dropout prevention, individual counseling and support, job training and job placement.

Most communities have relatively limited experience in the field of adolescent pregnancy prevention. Because of the increasing recognition of the necessity of focusing on primary prevention, many communities are developing a number of strategies, while others struggle to assess what additional efforts should be established. In many communities, those individuals who have worked in the area of capacity building have worked in a limited way with those engaged in the life options arena. The majority of professionals appear to have coexisted, often serving the same young person, without recognizing that other professionals may have been working concurrently with the same client.

While a number of youth-related services may already be in place within a community, they often fail to participate in efforts aimed at pregnancy reduction.

Increasing communication and joint efforts between youth care providers is an important goal of this document. Recognition of the need for multiple and concurrent strategies that help reinforce the message for young people to delay parenthood is a recurrent theme of the following strategies. While a number of youth-related services may already be in place within a community, they often fail to participate in efforts aimed at pregnancy reduction. Thus, the role of service providers must be extended and

expanded, so they can either directly present pregnancy prevention information or allow other agencies to do so in their settings (co-location). This bridging must occur in order to further integrate pregnancy prevention efforts into the lives of young people.

Assess Community Needs

We encourage communities to consider the following strategies for use and adaptation to the specific needs of communities throughout the country. Before proceeding, it is important to have a well-documented picture of individual community needs as reflected in the incidence and prevalence of adolescent pregnancy, as well as a sense of the prevalent attitudes toward the issue of adolescent pregnancy.

While a community may want to adopt a number of strategies simultaneously, it will be important to establish priorities, as well as to determine the most logical place to begin a comprehensive effort. For example: A community may not feel comfortable expanding family planning clinic efforts geared to reaching sexually active adolescents at risk of unintended pregnancy. It may choose, instead, to implement a comprehensive FLE program geared to reaching both in-school and out-of-school youth.

Another community may recognize that greater efforts to decrease the school dropout rate can impact adolescent pregnancy, because school dropout is an important antecedent as well as consequence of adolescent pregnancy. Realistically, each of the NRC recommendations (FLE, access to reproductive health services and improved educational opportunities), as well as a variety of reinforcing strategies, are needed to assure a successful effort to reduce the incidence of adolescent pregnancy.

The need for a comprehensive effort requires a number of people, organizations and agencies who previously have not been actively or directly involved. There is a need for new involvement and commitment by private, business, religious and public sectors. Those working in youth-serving agencies need to extend their focus to include a more active role. Agencies might, for example, develop information on adolescent pregnancy prevention to be part of the array of educational services that they provide.

As you review the following suggested strategies, consider what potential adaptations will be needed for each individual community site. For example: This report suggests that a wide variety of community-based organizations should be committed to integrating family life education as part of their youth-related activities, but a community may feel that certain organizations lend themselves more readily to this strategy than others.

Developing a timeline and a list of priorities for the following strategies will require a consensus-building process. Through this community-organizing effort, the community may develop its own specific strategies that best respond to the needs of its youth. We encourage creative efforts to develop action steps that will implement those strategies as well. ❑

Helping Teens Wait: Abstinence Education

Much of the debate surrounding adolescent pregnancy focuses on the morality of sexual activity, a difficult issue on which to build consensus and send a clear message. The issue is complicated by the flaunting of sexuality in the media and the lack of role models for teenagers who abstain from sexual activity or practice responsible sexual activity. Adolescents are caught in society's ambivalence regarding sexuality. As we search for solutions, we must deal with the plurality of values in American society and the gap that often exists between values and behavior.

Adolescents begin to feel anxiety about their changing bodies, but are often uncomfortable asking their parents or other adults for information and advice (Kirby, 1984). Their major source of sexual information is often an uninformed peer. The result of widespread misinformation is often increased sexual activity during vulnerable periods and greater incidence of teenage pregnancy (Pittman, 1986a). Some teenagers seem to have less knowledge about sex, conception and reproduction than others. One study found that young teenage males of all races and teenagers with less-educated parents had the least knowledge (Moore, Simms and Betsey, 1984).

This lack of information exists in spite of widespread national support for sex education. A 1985 Harris poll based on a representative national sample reported that 85% of the American people support sex education in the public schools and 67% favor laws permitting public schools to establish linkages with family planning clinics to provide contraceptive education and services.

Although FLE has not been shown to directly impact the adoption of contraceptive use, it has been shown to positively affect the following factors: (1) skills—students show improvement in communication and decision-making skills; (2) parent-child communication, resulting in a greater sense of comfort in discussing sexual issues within the family; and (3) knowledge, particularly for younger adolescents, on topics of birth control, STDs and the probability of becoming pregnant. Research has documented that attending FLE courses does not significantly increase the amount of sexual activity among students (Dawson, 1986; Marsiglio and Mott, 1986).

Nationally, levels of premarital sexual activity have increased since the 1920s, although premarital intercourse did not gain social acceptance until the 1970s. Proportions of sexually active teenage females 15 to 19 years old rose from 28% in 1971 to 42% in 1982.

Adolescents are caught in society's ambivalence regarding sexuality.

Increases in the levels of sexual activity were greater among younger teenagers than older teenagers (Zelnik and Kantner, 1980).

In searching for reasons for the rise in adolescent sexual activity and pregnancy, we should remember the changes that have taken place in our century. The age of physical maturation for girls has dropped sharply. The mean age at menarche, or onset of menstruation, in the United States is 12.6 years (Hofferth

and Hayes, 1987), a drop of about 4 years since the late 1800s.

The concept of adolescence as a distinct period of human development is relatively recent. Just over a century ago, children simply became adults. In recent decades the period between childhood and adulthood has lengthened. Independence is often postponed for significant periods of time while young people acquire the education and other skills needed in modern society.

Today's adolescents are reproductively mature long before they achieve social maturity. Previous generations were not confronted with this problem to the same degree, because the time between biological and social rites of passage was shorter; young people married and raised families earlier, not long after becoming sexually mature.

Trends in FLE

Across the country numerous efforts to encourage young adolescents to delay sexual intercourse until they are responsible and self-sufficient adults are underway. The goals of FLE programs are to reach adolescents early with information on how and why to defer sexual activity, to increase teenagers' awareness of pressures to become sexually active, to reinforce their ability to say no and to build assertiveness skills.

Most of these models utilize a curriculum and class teaching method to achieve their goals and target young teenagers (ages 12 to 15) in an attempt to reach students before they become sexually active. Many of the programs also involve parents by providing special information sessions and shortened versions of the curriculum, so parents can reinforce teenagers' learning experiences at home. Several of the curricula seek to build the assertiveness skills needed to say no to sex, while teaching young people the potential economic, social and emotional costs of early childbearing. It is difficult to evaluate whether these efforts to defer sexual activity among teenagers are effective in reducing adolescent pregnancy.

Abstinence Programs

One program that has been studied is the Postponing Sexual Involvement (PSI) program developed by Marion Howard and Marie Mitchell (Howard, Mitchell and Pollard, 1990). Aimed at 7th and 8th graders, the curriculum uses peer educators from nearby high schools. It is specifically focused on encouraging young people to delay sexual intercourse.

The PSI program is an intensive 4-part series, followed several months later by a reinforcement session. The curriculum emphasizes building both knowledge and interpersonal skills, thereby teaching young people both the how and the why of postponing sexual involvement.

Evaluation of PSI has demonstrated that both males and females who had not yet had sex and who participated in the program were subsequently much less likely to engage in sex than were similar students who did not participate in the program. When participants engaged in sex after the course, they did so less frequently than did nonparticipants. The program did not have a measurable impact on students who had engaged in sex prior to the beginning of the course (Kirby, 1989).

Other FLE programs that emphasize abstinence have been recently evaluated. One such program is the 15-hour curriculum developed by the Search Institute entitled "Human Sexuality: Values and Choices." The program is aimed at 7th and 8th graders. Parents participate in 3 additional sessions (Donahue, 1987).

A comparison of attitudes measured immediately before and after the program revealed significant changes in the following areas: increased belief that intercourse can result in pregnancy or STD, increased support for sexual restraint in adolescence, decreased intention to engage in intercourse while a teenager, decreased support of coercion in sexual relations and increased frequency of conversations with parents about sexuality (Kirby, 1989; Donahue, 1987). These changes, however, quickly diminished. Three to 4 months later, none of the changes remained statistically significant ex-

cept the increased belief that intercourse can lead to pregnancy or STD.

Research supports a correlation between parent involvement and delay in the initiation of sexual activity, spurring the development of parent-child communication programs that encourage stronger familial involvement in the teaching of values (Kirby, 1989). For example, mother-daughter and father-son workshops are designed to increase communication between parents and their children in the context of learning more about adolescence and sexuality. Participants in many of these programs also receive homework assignments that require families to set aside 20 minutes to discuss family values and the topics covered in class.

Topics oriented to younger adolescents (ages 9 to 12) include body image, self-esteem, puberty, menstruation, human reproduction, peer pressure and decision making. Classes for older adolescents (ages 13 to 16) explore these topics in greater depth, as well as sexual decision making, the difference between love and lust, STDs and adolescent pregnancy.

Some of the programs serve parents only and focus primarily on parent-child communication.

Such programs do appear to increase communication between parents and children (Solem and Associates, 1982; Donahue, 1987), although the effect is relatively weak. The type of behavior affected apparently depends on the gender of the parent and the child, the values of the parents and the message that is transmitted (Kahn, Smith and Roberts, 1984; Moore, Peterson and Furstenberg, 1986)—factors which are usually not under program control (Hofferth and Miller, 1989).

A Multipronged Model

In 1982 one South Carolina county began a multipronged public health information and education intervention project aimed at reducing adolescent pregnancies and births. Intervention messages were targeted simultaneously at parents, teachers, church representatives, community leaders and children enrolled in the public school system.

The messages emphasized developing decision-making and communication skills, enhancing self-esteem, understanding human reproduction and using contraception. South Carolina's family life education program reported that in 1984, the pregnancy rate and the number of live births dropped 50 percent in the county in which the program operated, a significantly greater reduction than in 3 nearby sociodemographically similar counties (Vincent, Clearie and Schluchter, 1987).

The extent to which the results of the South Carolina intervention can be predicted for other regions is limited by the distinct rural nature of the target population, the small numbers of pregnancies that occur in this area, and the difficulty of determining exactly what the intervention was and what behaviors it affected (sexual intercourse, contraception or the reporting of abortion). Further follow-up is needed to see how long the effect lasts (Hofferth and Miller, 1989).

Although a number of these research questions remain unanswered, the community-wide and multipronged model exemplified in the South Carolina program holds promise for further efforts aimed at adolescent pregnancy prevention as part of a community-wide health promotion campaign.

In addition to school programs, community-based FLE programs attempt to foster responsible decisions about sex. All programs are targeted at either teenagers or their parents. In an attempt to help parents become their children's primary sex educators, some of the programs serve parents only and focus primarily on parent-child communication.

Teaching Life Skills

Another educational approach that has received increased attention is known as the cognitive behavioral model (Schinke and Gilchrist, 1984). This approach, also called the

life skills counseling model, is based on the premise that many adolescents lack not only relevant information but also the cognitive skills to understand the consequences of their actions and the potential repercussions of adolescent childbearing. They also lack the behavioral skills needed to communicate with a partner about refusing to have sex or using contraception; their adolescent "magical thinking" helps them deny their sexual activity.

In this model, learning responsible behavior is understood as a 4-step process in which young people: (1) need access to relevant information on which to base decisions and behavior; (2) must perceive, comprehend and store information accurately; (3) must personalize information in making effective decisions, including relational thinking; and (4) need behavioral skills, including interpersonal skills training, to implement these decisions in social situations.

In terms of pregnancy prevention, preliminary evaluations based on a small sample of 44 program participants and 49 controls have demonstrated that youths who participate in these training programs are more knowledgeable about birth control and problem solving, develop better communication skills, have more favorable attitudes toward contraceptive use, and are more likely to have used contraception at their last intercourse than subjects in the control group. This model has also been successfully utilized in smoking and drug prevention education programs.

A broader test of the life skills counseling model was conducted by ETR Associates beginning in the fall of 1988. In this study, 2 10th-grade classes in 24 schools were randomly selected to receive either a 12-session life skills treatment or the standard (control) curriculum. Outcome measures included knowledge and behavioral intentions and emphasized behaviors such as past and current sexual activity, contraceptive use and pregnancy. The research included a true experimental design, a large sample size and measurements before, just after, and 6 months after the program.

For the trained group, knowledge about reproduction and birth control, intentions to practice appropriate skills to avoid pregnancy and communication with parents about pregnancy prevention were significantly greater at posttest and followup. The trained group also tended to use more birth control—especially those who started to have sex after the program.

No differences in the frequency of sex, pregnancy scares or pregnancies were found. Although skill training programs alone should probably not be expected to prevent significant numbers of pregnancies, this program offers some promise of adding to the pregnancy prevention effects of allied school, home and community activities (Barth, Fetro, Leland and Volkan, 1990).

Peer Education

Other innovative family life education efforts include peer training and group counseling programs. The Teen Outreach Program (TOP) originated by the Missouri Junior League and local schools provides students with volunteer community service placements, as well as weekly support groups.

In the groups, students discuss adolescent pregnancy and sexuality, as well as their experiences in community work and the possible implications of those experiences for their own lives. In the third year of evaluation of this program, the TOP students began the year at somewhat higher risk of school failure and school suspension and more of them than the comparison students came from non-intact families.

In spite of these differences, at the end of the school year, the TOP students had far lower rates of school suspension and dropout, differences which persisted when background differences were controlled for. Participation in the program was significantly related to lower pregnancy rates. The 1-year follow-up data collected from a subset of students enrolled in the program show that while the school enrollment advantage of the TOP students persists over time, the lower pregnancy rates do not. This latter finding suggests that the program may have delayed some pregnancies and births.

Evaluation of the program is continuing and efforts to randomize students into treatment and control groups is currently underway—an improvement on the program's previous efforts

to identify a control group based on the identification of a similar friend by the program participants (Hofferth and Miller, 1989). Overall, these examples demonstrate that family life educators have made significant efforts to identify ways to provide effective FLE.

In spite of these school-based FLE efforts, recent national surveys indicate that a great proportion of school districts across the country still do not offer a comprehensive FLE program, which includes at least 4 out of 6 specific topics related to reproduction, sexual development and birth control (Kenney, Guardado and Brown, 1989). While four-fifths of the states either require or encourage the teaching of sex education, only two-thirds require or encourage schools to teach pregnancy prevention.

The pressing societal issue of AIDS and other STDs has contributed to the fact that all but 4 states are providing education in these related areas. Nationally, state and local district funding and curriculum attention for AIDS education has far surpassed efforts directed at sex education. Additionally, the teaching of abstinence has received a national focus and is included in the curricula of almost every state.

While states help establish curriculum and policy, local school districts, particularly larger school districts, often take a more comprehensive perspective on the range of FLE topics they cover. The districts also offer greater amounts of local support through curricula, training and other activities than do the states (Kenney, Guardado and Brown, 1989).

Mentoring and Other Role Models

Since the completion of the NRC document, there has been special interest in and a renewed focus on developing mentor programs. Young people adopt role models who significantly influence their behavior. Through this process, they learn to recognize and adopt more positive behaviors. However, research to assess the impact of mentor programs on preventing adolescent pregnancy and delaying sexual activity is almost nonexistent.

Because mentoring does not stand as a singular intervention approach, but rather as part of a comprehensive effort, it is particularly difficult to assess its contribution. For example, the Summer Training and Education Program (STEP), a life option program developed by the Public/Private Ventures group in Philadelphia, has incorporated mentoring as one of four components aimed at increasing school attendance, reducing school dropout, providing employment and reducing pregnancy rates.

STEP is a comprehensive 15-month program encompassing 2 consecutive summers. It is directed at 14- and 15-year-old youth who have demonstrated problems in school. Along with remediation in reading and math, summer work experience and an extensive life-skills curriculum, the program includes a mentor or advocate who meets on a regular basis with each participant. Each mentor provides or arranges for tutoring, monitors school attendance and progress, provides encouragement and support and refers students to other services as appropriate.

The assumption is that young people may be more effective than adults at communicating with their peers.

The STEP program is undergoing a rigorous evaluation, including the random assignment of nearly 5,000 youth to either the model treatment group or to a control group that simply received normal summer employment for youth. Preliminary results have demonstrated that the program did significantly increase math and reading skills, but did not increase or decrease sexual activity or use of birth control. Thus, it seems unlikely that it will significantly reduce pregnancy (Kirby, 1989).

The New York City Children's Aid Society includes mentoring as part of its comprehen-

sive strategy to prevent teenage pregnancy. This multipronged effort offers tutoring, college entrance and scholarships, comprehensive FLE, health care, jobs and savings accounts and a sports program. As in the STEP program, each participant has an assigned mentor or counselor who meets with him or her on a weekly basis. The mentors or counselors help with a variety of problems, often using a case management approach, providing direct counseling and helping adolescents gain access to services. Because the program is comprehensive, most of the participants spend much of their free time with other peers who are participating in the program, reinforcing the values expounded by the program. The program is currently undergoing its first formal evaluation.

Other mentoring programs are comprised of teen peer advocate programs. Defined as interventions, these programs have teenagers fill the roles of educator or counselor, outreach person or resource worker and/or advisor in the design of programs for teens (Dryfoos, 1988). The assumption is that young people may be more effective than adults at communicating with their peers. The Postponing Sexual Involvement program uses teen counselors to provide its message rather than relying on adults. Peer educators use a number of approaches to reach other adolescents, including informal street contact, school and community presentations and one-on-one contact in other settings.

Evaluations show that peer educator programs also positively impact the peer educators, in addition to improving the responsiveness of the agencies with whom they work. Teens gain self-esteem and self-assurance as a result of being a peer educator or counselor. However, evidence that these programs impact contraceptive use or pregnancy rates among adolescents is limited.

The Media and Teen Sexuality

Many feel that the depiction of sexually explicit material and the lack of responsible role models in the media have greatly contributed to the problems of teenage sexuality. Messages from television, radio, films, videotapes, song lyrics and advertising give young people the notion that abstinence would place them in an unpopular minority group. Broadcast and print media bombard teenagers with sexual imagery—in actual scenes of people engaging in sexual activities and in ads that use sex to sell products.

Studies show that teenagers witness approximately 20,000 scenes of suggested sexual intercourse and behavior, sexual comment and sexual innuendo in a single year of prime-time television viewing (Sprafkind and Silverman, 1981). These scenes rarely depict or even indicate the responsible use of contraception, and the major networks continue to block most contraceptive advertising. Nor is there any discussion of the likely consequences of sexual behaviors, such as unintended pregnancy or STDs.

Younger adolescents are much more likely than adults to think that television presents a realistic picture of such topics as STDs, pregnancy and sex. Older teenagers begin to approach adults' levels of skepticism about images conveyed by the media. Younger teenagers who have not had sex education and whose parents are not college graduates are most likely to believe in the realism of television (Harris and Associates, 1986). When adolescents see that premarital and extramarital sex are presented matter of factly, most often without mention of contraception, many perceive that this is the way all adolescents and adults behave.

The Center for Population Options (CPO) is the only national organization whose primary focus is on adolescent pregnancy. As part of that focus, CPO has developed a special media project based in Los Angeles that provides technical assistance to Hollywood script writers and producers as they develop stories related to adolescent pregnancy. The organization has worked closely with the major television networks to raise consciousness about the issues. It encourages the media to play an active role in increasing the amount of programming available on the subject of adolescent pregnancy. The organization also offers educational

seminars for media writers and producers and presents annual prizes for the most responsible media shows dealing with adolescent pregnancy. During the past 5 years, this project has made important inroads in encouraging media to play a more positive role in the field of adolescent pregnancy prevention, and its efforts have helped create models for working effectively with media.

The issue of HIV/AIDS has created new opportunities for a more responsible treatment of sexual themes. A number of television scripts have dealt with the need for safe sex and the use of condoms, although the focus continues to be preventing transmission of HIV, rather than the prevention of unintended pregnancies.

Strategies for Abstinence Education

The NRC panel suggests specific strategies to meet the challenge of helping adolescents delay sexual initiation. They are: provide sex and family life education, provide assertiveness and decision-making training, develop programs that provide role models to young adolescents and influence the media's treatment of sexuality.

Following are discussions of each of the strategies suggested by the panel, with suggestions from the convener group for steps needed to implement the strategies.

Offer Sex and FLE Courses

The NRC panel suggests that sex and family life education courses be implemented for grades K-12 as part of an extensive health curriculum.

Comprehensive, age-appropriate FLE that is culturally sensitive and teaches about the options of sexuality and reproductive behavior, decision making, relationships, child development and parenting must be coordinated with community services such as family planning and counseling.

Although homes and schools are seen as the sites where most young people can be taught, other community sites and organizations—such as voluntary organizations (Boy and Girl Scouts), religious organizations and health facilities—have important roles to play in reinforcing responsible, healthy behaviors. The sensitive nature of this education makes the roles of parents and communities vitally important. Comprehensive family life education is part of an effort to equip young people with the basic skills needed to function effectively in society.

The incorporation of FLE programs into public school curricula has been advocated strongly by a number of groups that feel that children and adolescents must receive accurate information in a supporting, trusting environment in order to develop a sense of personal responsibility for their sexual behavior. Other groups have argued that FLE in the schools is unequivocally wrong for 2 reasons: Placing FLE in the curriculum implicitly endorses the initiation of sexual activity and fails to transmit a value orientation that prohibits premarital sexual activity. Some groups believe that school programs should simply encourage abstinence prior to marriage.

Specific credentialing for sex education teachers, including formal course-work in human sexuality, should also be developed.

However, recent concern about AIDS and the former Surgeon General's call for AIDS education beginning in elementary grades reinforce the need for establishing FLE at all school levels. Even when comprehensive FLE courses are offered to students, another problem remains—how can students be motivated to utilize the information effectively?

Integrating FLE into the Curriculum

Adequately funded, comprehensive and coordinated health education programs that integrate FLE are needed for grades K-12. The programs need core standards on both the content and the instructors' qualifications. Comprehensive health and family life education should include the following components: health curriculum; sexual abstinence; family planning and reproductive health, including specific information on the consequences of teenage pregnancy; STDs, including AIDS; life-planning skills, including ways to strengthen self-esteem; sexual abuse prevention; tobacco, alcohol and drug education; communication, interpersonal relationships and decision making; and the influence of the media and society on sex roles.

A core curriculum can be integrated into biology or life science courses, but FLE can also be woven into social sciences and English. Content should be developmentally appropriate to students at each grade level and should target those students who may be at risk of health-damaging behaviors. Peer education and counseling, teen panels, and courses for parents should supplement the core curriculum, in order to teach and reach youths at different ages.

Any family life education program should include opportunities for students to increase their sense of self-respect and self-esteem. In addition, educators should work with literacy programs to incorporate family life and self-care issues into program curricula.

Well-trained health educators and teachers are a crucial component of program success. Specific credentialing for sex education teachers, including formal course-work in human sexuality, should also be developed.

It is important to designate responsibility to at least one teacher at each school for integrating this health education curriculum. Adequate funding is needed for culturally sensitive in-service teacher training, technical assistance and support services. Monitoring the quality of classroom education on an ongoing basis is also important.

Teachers should be helped to identify appropriate curricula, available materials and ways to work closely with parents and community groups, agencies and resources to maintain high-quality programs. In addition, teachers and counselors should be trained to identify students in need of counseling and referrals to community services such as drug treatment, family planning and family counseling centers.

As part of the FLE curriculum—and/or as part of a broader, comprehensive health education curriculum—life-planning materials are needed to illustrate how early childbearing creates a barrier to educational achievement. Information about available courses should be widely disseminated and implemented. Funding to implement existing programs, including adaptation to local community needs, should become a priority.

The message of pregnancy prevention should be incorporated into other coursework and extracurricular activities.

The message of pregnancy prevention should be incorporated into other coursework (e.g., biology, social sciences) and extracurricular activities (e.g., plays, film production, school newspapers). It is important to recognize, however, that many instructors will find the topic controversial and anxiety provoking. Thus, teachers need the appropriate training to comfortably convey this message.

Representatives of community organizations can also lend support and credibility in the development of comprehensive FLE. It is important to recognize that a community-organizing model is time intensive, and organizers also have to overcome some concerns regarding the teaching of family life education in the school setting.

Implementing FLE Programs

The convener group proposed the following activities to help communities develop and implement FLE programs that work. Poli-

cymakers and other funders, parents, school district administrators and teachers committed to providing comprehensive FLE in the schools and other community settings are key people in implementing these activities.

Policymakers and other funders:

The role of policymakers includes developing state and federal policies and programs that encourage and strengthen sex education and family life programs. Adequate funding for training and technical assistance for community development, as well as release time for staff development, are necessary components of this activity.

The backing of other state and local legislators is also important to encourage adequate funding and support of mandated health education programs that include comprehensive FLE. However, because of FLE's value-laden nature, parents and local communities must be able to opt out of programs.

Efforts to secure funding will be more successful if advocating for such funding becomes less categorical in nature and focuses on more comprehensive health education curricula. These educational programs would include all the generic skill-building components (decision-making, self-esteem and communication skills) needed to avoid high-risk behaviors of all kinds. Sex education should be included in comprehensive health education legislation or appropriations at the state level.

A number of different private and public funders should be involved in supporting efforts to further disseminate well-evaluated comprehensive FLE curricula that emphasize communication skills and decision making. Adequate support should also be made available to adapt available curricula to the cultural and language needs of specific communities.

Funds should also be provided to schools or school districts for the evaluation of the impact of local sex and family life education on the knowledge, attitudes and behaviors of adolescents. While local districts may not be able to conduct a large-scale evaluation, they can share information with policymakers and the community at large. Such an evaluation effort should be implemented after funding for a core curriculum is in place.

Funders should also support collaborative efforts between schools and community-based organizations to deliver quality FLE courses appropriate to the community settings.

School district administrators and teachers will play a major leadership role in these efforts. It is important to consider, therefore, the specific strategies that can be implemented in their communities. The following suggestions may help these key people assess what efforts are already successfully underway and what steps will be needed in the near future.

School districts and teachers can:

- Develop a community advisory board comprised of representatives of parents, students, clergy, community organizations and business leaders to enhance community support of the teaching of comprehensive FLE.
- Provide technical assistance on the part of state departments of education to communities needing assistance in building community support.

Encourage parents to review course materials and participate in homework assignments to improve parent-child communication.

- Ascertain the status of FLE in a school. Depending on findings, organize the community to request that a FLE program be implemented and/or a current program be expanded and improved.
- Assure that quality FLE programs are implemented by meeting with appropriate school personnel, including the school principal.
- Conduct an initial indepth review of an existing FLE curriculum, including content, teaching materials and length. Based on these initial findings, assess what additional course materials and teacher training are necessary to expand and improve the program.
- Implement culturally relevant materials

that reflect the values of the diverse cultural backgrounds represented in the classroom.

- Disseminate information about programs that teach assertiveness and decision-making skills that can be included in existing FLE programs.
- As new programs are established, monitor FLE course materials, content and personnel involved in teaching the courses on a periodic basis. Members of the community advisory board as well as school administrative staff should be involved in this effort.
- Work collaboratively with other school districts and other community-based organizations in developing quality sex and family life education programs. Before districts develop their own courses, they should take maximum advantage of existing curricula.
- Provide preservice and inservice training to teachers through workshops, university courses and seminars at no cost to teachers on released time. Funding is key in accomplishing this strategy, for without financial support, school districts cannot afford to train teachers.
- Implement classroom supplements to formal teacher inservice training by bringing people with FLE expertise into the classroom.
- Evaluate health education teachers on their knowledge and skills.
- Encourage parents to review course materials and participate in homework assignments to improve parent-child communication. Parent education materials should be developed to accompany classroom-based instruction.
- Offer parent education seminars to help parents communicate with their children about sexuality and other important issues.
- Encourage school system personnel, including teachers, program administrators and principals, to share their family life and health education curricula experience with others at conferences and seminars.
- Educate both the private and public sectors, as well as parents, regarding the importance of comprehensive health education. In order to gain support, this type of education must appeal to the voting community.
- Organize at the local and statewide level to gain support from parents, students, educators, communities and state government for comprehensive FLE programs and to enhance awareness of the need for a viable program for local school districts.
- Develop effective funding mechanisms to implement comprehensive and coordinated programs. Use civic and statewide organizing efforts to gain financial support and priority for their implementation.

Develop Role Model Programs

The NRC panel suggests that programs should provide role models to young people to positively influence their behavior.

A variety of approaches have been developed to offer different role models to young people. Inter-generational efforts help young people consider a range of employment opportunities. Peer educators, slightly older than the adolescent, seem to have more credibility than adults. Peer educator programs in which young people provide FLE have been developed at both the junior and senior high school level. Some programs have developed panels of young parents who share their life experiences with younger adolescents to help them make wiser decisions.

Greater efforts are needed to discourage media's reliance on the use of sex as a tool for selling products.

Community-based organizations, including religious organizations, should be encouraged to help children in their community become more responsible adults as part of the overall skill-training they provide. Children should be encouraged to become active participants in community-supported activities (day care centers, soup kitchens, etc.) to allow them to feel part of the community and to feel responsible.

Special consideration should be given to providing access to responsible adults who can counsel youth on sexuality issues. Special programs should be developed to provide

counseling and education to students just entering puberty. School counselors should also be trained and supported in their efforts to counsel adolescents on sexuality issues.

To prepare a cadre of professionals who can conduct such programs, trained social workers, teachers, nurses and other professionals should conduct workshops to adequately prepare school staff to provide this type of counseling. Social workers and nurses should also be encouraged to provide one-to-one counseling services in the school setting. Confidentiality should be an important component of these programs.

Implementing Role Model Programs

The following activities can help communities develop and implement programs that provide role models to young people as a way to influence their future. Key players include school and community agency staff, voluntary associations that serve youth, and policymakers in each of these institutions, whose commitment is necessary to develop and fund role model programs.

School and community agency staff can:

- Develop and implement training workshops to prepare key contact people in major spheres of the adolescent's life to deal with adolescent sexuality issues in a sensitive manner. Important contact people for youth include nonteaching school personnel, such as guidance counselors, nurses, coaches and principals, and staffs of welfare, social, health and recreational agencies.
- Organize after-school activities that provide recreation, social support and school mentoring as a means of increasing positive youth development.
- Develop mentor and role model programs connecting local industry and schools. Encourage the school's graduates to return and discuss their careers and jobs.
- Designate a specific staff member at each site to coordinate mentoring activities.

Youth-serving voluntary associations can:

- Provide special training for professionals who will be involved in establishing role model or mentoring programs.
- Recruit popular teenage and adult celebrities to serve as positive role models in a number of media campaigns aimed at providing messages about the value of adolescents and their potential contribution.
- Establish a variety of community-based programs wherein mentoring relationships between adolescents and pre-adolescents and adult organization members can be established. The Big Brother/Big Sister programs are good models for these efforts.
- Implement education programs for parents that enable them to be positive role models for their children. Parents need to be given the comfort, knowledge and skills to communicate their values to their children. They also need to understand that their behaviors often speak louder than their words.

Policymakers can:

- Create volunteer, apprenticeship and paid job opportunities, depending on the ages of students, to expose them to the world of work and positive work mentors.
- Provide incentives, such as financial rewards for successful academic performance and tuition scholarships, to encourage young people to participate in mentoring programs.
- Provide incentives to employers to create mentor partnerships with teens (e.g., part-time internships wherein the mentor can work closely with the adolescent).
- Provide technical assistance and training to local community agencies interested in developing special mentoring programs to reach at-risk youths.
- Provide funding for evaluation of programs that offer positive role models for young adolescents. As many of these activities have not been formally tested, pilot programs need to be developed, implemented and evaluated before wider dissemination is recommended.

Balancing the Media Message

The NRC panel recommends that efforts be made to influence the media treatment of sexuality.

The media are important in shaping the messages young people receive about gender roles and sexual behavior. We are bombarded with sexual messages, but we are rarely shown the consequences of irresponsible sexual activity. Media representatives should gain an understanding of the issues and influence of the media on sexual values and beliefs.

Media should reduce the exploitation of sex and violence and demonstrate their commitment to depicting positive and responsible sexual behavior. Television programming should evolve into a more positive influence on teenagers' sexual attitudes and behavior.

It is important to achieve a balance between media's commercial interests and society's concern for the consequences of premarital and extramarital sex. As powerful modeling tools, the media could teach young people communication skills by showing characters who successfully discuss sensitive topics, such as abstinence and contraceptive use. Because of its influential role, the media must be encouraged to effect a responsible approach to programming, including a decrease in the use of sex and violence in advertising and programming.

Media should also provide more realistic and positive portrayals of life, including accurate depictions of diverse cultures and avoidance of stereotypes. Violence and sex should not be shown as solutions to problems. The media should be encouraged to stop glamorizing premarital and extramarital sex and teenage parenthood and to present more positive, responsible and realistic messages to youth in the areas of sexuality and violence.

Media should work toward portraying characters in situations where they model responsible sexual behavior and increase overall time devoted to public programming that depicts these issues. Greater efforts are needed to discourage media's reliance on the use of sex as a tool for selling products.

Develop and expand efforts to conduct media campaigns aimed at responsible sexual behavior. Media campaigns have been widely and successfully used to educate the public about dangers of drinking and driving, as well as drug use. Again, diverse cultural backgrounds should be reflected in all media efforts.

While resolving the issue of adolescent pregnancy requires complex efforts, a media campaign can be an important part of a comprehensive plan of action. The media can play a valuable role in bringing public attention to the topic and helping create a supportive climate for change. Several national organizations, such as the Children's Defense Fund, Planned Parenthood and the Urban League, have developed a series of media campaigns used in a number of communities across the country.

Further efforts to incorporate these campaigns on a more systematic basis are needed. Increasing attention has been paid to encouraging sexual abstinence, particularly among young adolescents. With this age group in mind, it would serve to conduct a close review of the impact of "just say no" campaigns in the areas of drug abuse. The media campaign should also focus on those adolescents who are sexually active and provide them with important information on contraceptive care and where services are available.

Implementing a Media Campaign

The following activities can help communities develop strategies to make the media an ally in efforts to prevent adolescent pregnancy. Key players include community-based organizations and advocacy groups, policymakers and researchers, as well as the media itself.

Community-based organizations and advocacy groups can:

- Conduct a public campaign to encourage national networks to be more responsible for their depiction of sex and birth control methods. Obtain community and professional support for a campaign for more balanced programming.
- Educate advertisers, television and film producers and the FCC about the problem of adolescent pregnancy, and encourage them to increase programming aimed at preventing teenage pregnancy.
- Work in conjunction with the media in developing more educational content for regular programming, including characters facing and discussing the consequences of sexual relations, unwanted pregnancy, AIDS and other STDs, and early parenting.

- Develop a national campaign to promote advertising for contraceptives on television and radio.
- Develop positive letter-writing campaigns for media efforts that exhibit high levels of responsibility.
- Develop learning opportunities, such as classroom reviews of media programs that encourage teenagers to overcome pressures to engage in sexual intercourse at an early age.

Media representatives can:

- Expand the media's role in reaching young people with messages of responsible sexual behavior.
- Develop public service announcements that present responsible messages during prime time.
- Increase public awareness of the availability of community services through highlights in the media (e.g., news specials, guest speakers, interviews with teenagers).
- Establish community radio shows that provide information for teenagers in an appealing manner.
- Develop and implement large-scale media campaigns using pop radio, videos, posters, resource cards and bumper stickers.
- Conduct campaigns to reach teenagers of diverse cultural backgrounds, using media that are popular with the targeted population, such as Spanish language radio and television stations.

Policymakers and researchers can:

- Provide state and local funding to support media programs that convey positive messages to adolescents about healthy sexual development and responsible sexual behavior.
- Collect data, including contextual analysis, and conduct research to assess the influence of media on children under the age of 18, especially in the areas of sex and violence. Results of these studies should be widely disseminated to advertisers, publishers, filmmakers and music and television producers.
- Evaluate the effectiveness of various media approaches to determine which approaches to use for different teen samples in the population.

Barriers to Implementation

There are a number of potential barriers to implementing the previous recommendations. Barriers are evident among young people themselves, the organizations, programs and social systems that interact with young people, and the values demonstrated in the greater society.

The nature of adolescence contributes to the problem of finding ways that young people will become more responsible about their sexuality, including the decision to delay sex. Many adolescents are unable to reconcile the divergent voices in their environment. While some voices argue for delaying sexual intercourse, adolescents also hear internal (physical) and external (peers and media) voices encouraging sexual activity. The inability to reconcile these different messages often contributes to passive decision making among adolescents.

Responsible sexual behavior is taught by education that models responsible sexual behavior, including abstinence. Adolescents also need high self-esteem and self-respect. Many are struggling with their conceptions of themselves and how they fit into the adult world. Their self-definition often revolves around their sexuality. The teens most likely to engage in early sexual activity may be those least likely to participate in organized programs that emphasize abstinence.

While some voices argue for delaying sexual intercourse, adolescents also hear internal (physical) and external (peers and media) voices encouraging sexual activity.

In addition, schools often fail to communicate to young women from a very early age that they will have financial as well as family issues in their futures. The lack of hope that many

inner-city youth feel regarding their future is also a major barrier. Many adolescents feel, often unconsciously, that if there's nothing to look forward to except poverty, then there may not be any real loss in their lives if they do have a baby. The immediate gratification of sexual activity may not be offset by any other viable alternative in the adolescent's life.

Two important external factors often contribute to barriers encountered by young adolescents. The sexual partners of many teenage women are older adult men. As a result, young people often become victims of sexual exploitation. A common challenge is to help young women deal comfortably with the question of sex when involved with someone older and to build refusal skills if they are not ready. For many adolescents, sexual initiation is generally understood to equal sexual intercourse. Few adolescents learn that other modes of physical sexual expression exist.

The sexual exploitation of American teenagers is best exemplified by mass media pressure to be sexy and engage in sexual activity.

Efforts at encouraging abstinence should emphasize increasing concerns about adolescents' risk for AIDS and other STDs, as well as the risk of early pregnancy.

Media images are not only destructive in the area of sexuality, but they heavily impact the images young women have about themselves and their concerns, as well as their futures. In addition, society's double standard—the relative acceptability of sexual behavior for boys—works against efforts to get teenagers to delay sexual activity.

Another major barrier is the fear that teaching adolescents about sexuality will encourage them to become sexually active. A second implication is that this type of teaching appears to condone sexual behavior. This implies that information about sex is harmful. It assumes that teaching adolescents to just say no will solve the majority of problems in this area. Abstinence education is far more complex.

Overcoming Barriers

Efforts at encouraging abstinence should emphasize increasing concerns about adolescents' risk for AIDS and other STDs, as well as the risk of early pregnancy. These dual risks occur at a time when developmentally young people feel they are immune to any bad things happening to them, increasing the challenge of educating students about their risks.

One successful approach in AIDS prevention has been to bring young people with AIDS into the classroom to discuss their experiences. Other programs have developed teen panels of young mothers and fathers who discuss their experiences as parents. These approaches help young people understand that such experiences could really happen to them. Abstinence can then be seen as one way to reduce the risk.

In addition to receiving information, young people need to develop a variety of skills that can help them choose abstinence without the fear of losing their boyfriends or girlfriends. This is an especially challenging problem for adolescents.

Effective education programs geared to young people before they initiate sexual activity can help them delay sexual involvement. As demonstrated by the Postponing Sexual Involvement program, programs emphasizing abstinence are most effective when they include multiple educational sessions, are taught relatively early in the curriculum (8th grade) and have a strong peer leadership component (e.g., program is taught by a 12th grader).

Based on the experience of the PSI program, additional components have been developed to assist the younger preteen, as well as to reinforce the abstinence message as students reach the 9th and 10th grades. For students at the 5th and 6th grade level, the program curriculum includes information to help them

handle their curiosity about sexual involvement and develop attitudes and skills to manage sexual behaviors as they become young teenagers. The program aimed at middle adolescents reinforces the information and skills they gained in the 8th grade (Howard and McCabe, 1990).

These 3 curriculum components are combined to provide young people with a reinforcing and consistent educational message along with additional skill development. These efforts clearly point out the need to provide young people a greater number and variety of educational experiences to help them develop a repertoire of skills that enable them to say no without alienating their peers.

As part of the wider community effort, parents and other family members may need information and support for ways that they can help reinforce the message of abstinence.

It is also important to reconsider the type of FLE that is provided to young people. While great strides are being made in increasing the number of curriculum programs that include decision-making and interactive skills, teens need to learn that there are a number of ways they can explore their sexuality without placing themselves at risk for unwanted pregnancy or disease. Broadening the definition of sexual activity to include hugging, holding, etc., (commonly called outercourse by sexuality educators) should be included in educational programs.

At the community level, it is important to provide additional support to help young people understand the advantages of delaying sexual involvement and early childbearing. Many young people become sexually active at an early age because they lack sufficient supervision and interests to occupy their time.

Greater integration of young people into the community can be achieved through voluntary or paid part-time positions, career and vocational exploration, after-school recreational and cultural learning experiences, along with tutoring and peer counseling programs. While these efforts may not necessarily help young people postpone sexual involvement, they provide young people with options that help them explore a variety of learning channels. Many of the life options efforts geared to increasing young people's motivation to delay early childbearing can also help young people delay sexual activity.

As part of the wider community effort, parents and other family members may need information and support for ways that they can help reinforce the message of abstinence. This training should help parents understand adolescent development and the ways they can effectively teach family values to their children—including reinforcement for the message of abstinence. Ideally, this training should be provided parents when their children are preteens.

Finally, working with the media is an important strategy. Media play a vital role in shaping the perceptions of young people and must be held accountable for the "sexploitation" they often engage in. Young people need to be made aware of the media's role in promoting sexual exploitation. Efforts to work with the entertainment industry and advertisers to create messages that support abstinence and sexual responsibility must continue.

A number of concurrent strategies can help young people deal with the issue of abstinence and the complexity of saying no. While the task of changing social norms is difficult, recent successes in decreasing both smoking and drinking and driving behaviors hold promise for changing norms surrounding sexual behavior. ❑

When Teens Don't Wait: Encouraging Contraception

The NRC panel believes that to reduce early unintended pregnancy, sexually active teenagers must be encouraged to diligently use contraception.

As public awareness of the problem of teen pregnancy and its personal and social costs increases, so does the debate about methods of addressing the problem. Many believe that delaying the initiation of sexual activity is the only acceptable method and that strategies should include only programs that emphasize abstinence. Others argue that additional methods should be developed to reach young people who are sexually active. These strategies would include services to help teens delay pregnancy, primarily through contraception, with parenting, adoption or abortion available in the event of contraceptive failure. In this era of widespread sexual activity, young people and their parents must be offered a variety of strategies that reflect diverse value systems (Brindis and Jeremy, 1988).

Successful efforts to encourage contraception among adolescents presuppose that a strong and effective family planning delivery system is fully in place. Creating a positive climate for adolescents to fully adopt and comply with a regimen of contraceptive care also implies that services are accessible and acceptable to the adolescent client.

Creating an Active Constituency

New and renewed efforts in the area of reproductive family planning services are needed, particularly as the risk of STDs, including HIV infection, raises the stakes for adolescent health. National leadership is necessary in supporting core family planning services for women of all ages. Without federal standardization of policies, care and services, diversity in the states' actual provision of care would prohibit equal access to care.

As a national priority, an expanded constituency must be developed around the issue of family planning to advocate the support of ongoing family planning programs. This constituency can be built through a renewed effort at reaching a broader array of other coalitions.

Family planning providers and agencies must play an active role in creating partnerships with families, schools, churches, clients, other service providers, media and businesses to implement strategies for reducing adolescent pregnancy. Many of these partnerships become the basis for establishing coalitions that can advocate on behalf of adolescents and their right to receive confidential contraceptive services, as well as other community development efforts impacting youth. Coalitions can reduce duplication and greatly enhance the development of coordinated strategies. Before the implementation of many of these strategies, communities must be well informed about the problem and consequences of unintended pregnancy. This education helps build community consensus about strategies to implement at the local level, including increasing access to contraceptive services.

In addition, family planning supporters must work with other coalitions to support efforts to deal with issues that are impacted by the topic of family planning. These include such diverse groups as those representing labor and em-

ployment and constituents concerned with child abuse.

Federal and statewide policies that include adolescent pregnancy prevention and access to family planning services are needed to provide overall direction to private and public institutions. These efforts should also recognize the context of adolescent social, health, education and employment needs.

Although public and private institutions can play a leadership role, individuals and communities throughout the states must accept their role and responsibility in working toward viable solutions and decreasing the many barriers to family planning services for adolescents. While significant policy changes are needed, as an interim step it may be necessary to work on building and evaluating model programs, which in turn impact the development of new policy directions. Both efforts are needed to deal with the complex area of adolescent pregnancy prevention.

Collaboration at the federal, state and county levels is needed. Key agencies include state departments of health services, education, social services, employment, drugs and alcohol, etc. Political and financial support is necessary to make adolescent pregnancy prevention policy a reality.

A coordinated public policy requires the commitment of communities, agencies and public policymakers; the most effective use of available funding through coordination; and the development of viable private and public partnerships supporting the funding of programs aimed at postponing pregnancy. Chief among these activities should be a commitment to increasing family planning services. Such a policy also requires the development of a strong political base in order to place the topic of adolescent pregnancy prevention on the agenda. Extensive efforts are needed to expand existing family planning programs.

These efforts require overcoming the image of controversy that has recently surrounded family planning, largely as a result of the controversies associated with abortion. Some groups argue that existing methods of contraception, such as IUDs and birth control pills, are in the same category as abortion. It should be widely emphasized that family planning services are needed to prevent the occurrence of unintended pregnancies.

The State of Service Delivery

A renewed commitment to prioritize access to family planning care for sexually active young people is necessary. We also need to critically reexamine the quality of service delivery systems and consider adopting innovative systems. Several innovative clinic programs have incorporated contingency counseling—including assigning clients to specific counselors, ongoing and closer follow-up, and case management of services—to increase both contraceptive compliance and clinic continuation (Namerow, Kayes and Weatherly, 1987; Armstrong, 1988). Their successes affirm the need to expand counseling services and increase the reimbursement mechanisms available for these services.

These strategies...will not be effective unless there are important changes in the social norms surrounding the use of contraceptives by young people.

As the variety of family planning agencies available within a community increases, higher numbers of clients will be served. These agencies increase the availability of services and the capacity to tailor services to the specific needs of different segments of the target population (Torres and Forrest, 1983). Special outreach and educational services have been shown to be effective in recruiting clients who hesitate to seek care. Unfortunately, such services are often the first to be eliminated when programs

face cuts. There is also a recognized need to increase the variety of contraceptives available. The nature of adolescent sexual activity, often episodic and spontaneous, creates the need for special contraceptives, including postcoital methods.

The NRC recommendations include specific policy, research and funding strategies to meet the goal of improving access to and use of family planning methods by sexually active adolescents. These strategies, however, will not be effective unless there are important changes in the social norms surrounding the use of contraceptives by young people.

Many of the strategies that follow are directed specifically to policymakers, program managers, researchers and the community at large. These categories are not meant to be mutually exclusive. The responsibilities of implementation are not the sole territory of any one group.

There is currently no national policy or plan for increasing adolescent access to family planning services. In fact, some of the current policies in this arena counter efforts to expand family planning services. Too few national efforts are underway to address the issue in a cohesive manner. Thus, in the absence of a national policy, it is imperative that national organizations and their constituents join efforts at the local, state and national levels to complete as many of the following strategies as feasible.

Strategies for Encouraging Contraception

The NRC panel recommends specific strategies, including: Use public education to encourage use of the birth control pill and dispel myths about its health risks; explore nonmedical models for distribution of the pill; continue public support for contraceptive services to adolescents; ensure that sex education programs provide information on methods of contraception; use a variety of contraceptive models to reach adolescents; develop and refine school-based service models.

Educate the Public

The NRC panel suggests public education to encourage use of the birth control pill and dispel myths about the health risks of pill use by teenage girls.

There is a major void in the amount of information that is provided to the public regarding contraceptives, and the topic of family planning services is rarely evident in the media.

Throughout the past few years, conflicting reports have often left the public with the image that the birth control pill is no longer safe. Yet, a number of research studies indicate that the birth control pill is the most effective and one of the safest methods of contraceptives available, especially for adolescents. It is imperative that clear information be provided to the public in general—and in particular to young people, who may not be able to reconcile conflicting information.

The ambivalence with which sexuality is treated in our society tends to spill over to the birth control method itself.

The ambivalence with which sexuality is treated in our society tends to spill over to the birth control method itself. The idea of responsible sexual behavior has been accepted consistently by a relatively small proportion of the adolescent population. The lack of clear societal messages regarding the importance of contraceptive use keeps adolescents in a state of denial about the possibility of unwanted pregnancy.

To overcome these developmental barriers, an intensive social marketing campaign is necessary. Recent successes in changing the

social norms regarding smoking and the adoption of safe sex practices among adults are promising. These efforts demonstrate the impact of programs that integrate multiple, simultaneous information strategies transmitted with a consistent message. These strategies have included personalized health education, interpersonal communication skills and environmental policy changes. In the case of AIDS, the impact of loved ones dying of the disease has also had a dramatic impact.

To promote contraceptive use, marketing approaches need to be appropriate to the target adolescent population, while remaining sensitive to community values. Young people need to be empowered with accurate and complete information, as well as the necessary decision-making and behavioral skills.

Successful marketing strategies integrate family planning with other health promotion efforts directed at youth. For example, a campaign aimed at empowering young people to take greater responsibility for their well-being could encourage them to increase control in many areas, including choices about nutrition, exercise, fertility, tobacco, alcohol and drug use.

Implementing Public Education

The convener group proposes the following activities to help communities develop and implement a campaign to encourage use of the birth control pill and to dispel fears about health risks. Community health educators, health care providers and the media are important in creating a successful campaign.

Community health educators and health providers can:

- Expand the efforts of professional organizations, such as the American College of Obstetrics and Gynecologists, American Medical Association, American Academy of Pediatrics and Planned Parenthood Federation of America, to educate the public regarding the importance of contraceptive use and the safety of the birth control pill.
- Develop and use specific marketing strategies to effectively reach adolescents with accurate information on methods of contraception, particularly the birth control pill.
- Given the risk of AIDS and other STDs, inform teenagers about the advantages of combining the use of birth control pills and condoms.
- Use peer educators to develop approaches and messages tailored to reach teenagers in a specific community. For example, organize rap contests, theater groups, etc.
- Use peer educators and counselors to help increase the social desirability of using contraceptives.
- Train teachers, and educate students directly about contraception, including the safety of using the birth control pill.
- Encourage clinic personnel and private physicians to work with schools, churches and youth groups to effectively channel information about contraception to young people.
- Create community-based health education programs that include contraceptive issues among other health issues (e.g., blood pressure, diabetes, nutrition, etc.) to work with mothers, aunts and grandmothers of potentially at-risk teenage women. It is important to develop strong social networks of individuals in the adolescent's life who are able to support the young person's decision to use contraceptives.
- Train community outreach workera.
- Educate the media about the risks and benefits of contraceptive methods.
- Involve the media in a public education campaign on contraceptives.
- Solicit advertising and publish stories in teen magazines on the risks and benefits of contraception.

The media can:

- Alter network policies to allow for paid contraceptive advertising.
- Develop and widely disseminate public service announcements that present responsible sexuality messages during prime time.
- Increase public awareness of the availability of community services, such as family planning clinics. Possible methods include news specials, guest speakers and interviews with teenagers.
- Establish community radio shows that provide teenagers with information about contraceptives in an appealing manner.

Expand Channels for Distributing Contraceptives

The NRC panel recommends that contraceptive service programs explore nonmedical models for distribution of the pill.

A significant development that has received increasing attention since the release of the NRC report has been the impact of AIDS and the potential vulnerability of young people to this STD. As a result, dramatic efforts have been made to increase community education about the disease's transmission and ways to have safe sex, as well as to expand channels for condom distribution.

Another emerging issue relates to the wide use of crack cocaine and other drugs among youth and the associated exchange of sex for drugs.

Ironically, many of these efforts directed at heterosexual couples have not related the information to pregnancy prevention. In addition, while the birth control pill continues to be the most effective method of contraception, the potential life-threatening danger of HIV/AIDS has prompted the need for young people to use a combination of contraceptive methods to protect themselves from both unintended pregnancy and STD. Thus, this section expands the NRC group's primary focus from birth control pills to a broader category of contraceptive distribution, with a special focus on condoms.

Many young women fail to seek contraceptive care because they are afraid of the pelvic examination required before they can receive a prescription for birth control. Current research being conducted by the Southeast Family Planning Council of Pennsylvania is testing whether the removal of this barrier, by postponing the initial physical exam, will encourage young women to seek earlier care (Armstrong, Samost and Herceg-Baron, 1989).

The requirement for a pelvic examination prior to dispensing birth control was instituted because of public health concerns. Family planning clinics are major entry points into the health care system for many women, especially poor women with no other access to health care. The family planning visit provides an opportunity to screen for cancer, STDs, high blood pressure and diabetes.

While these are important health services, they are not necessary prerequisites for prescribing oral contraceptives. Many adolescents are not necessarily at risk for these health problems. Where the pelvic exam has been shown to be a deterrent to seeking care, professionals are weighing the advantages of getting a teenager on a contraceptive method against the risks of unintended pregnancy if deterred from seeking care. Once trust has been established, the pelvic exam can be provided later.

Several professional organizations, including the American College of Obstetrics and Planned Parenthood of America, are considering the separation of public health screening components from the distribution of family planning methods. If this separation is fully implemented, it will have major implications for the role of pharmacists in the distribution of different contraceptives, as well as for the potential distribution of contraceptive methods in other settings, such as grocery stores.

Another emerging issue relates to the wide use of crack cocaine and other drugs among youth and the associated exchange of sex for drugs. Tragically, some young women who use crack get pregnant and deliver babies that are addicted to the drug. New efforts are needed to reach this vulnerable population, which often does not use traditional services. Given the limited treatment available for pregnant addicts, the issue of pregnancy prevention, along with drug prevention and opportunities for drug treatment, will continue to be increasingly important.

It is important to consider offering family planning services in nontraditional settings, including drug treatment sites. If a full array of family planning services cannot be made available at these sites, providers will need to weigh the importance of averting unplanned pregnan-

cies among this population against the risk of not being able to provide screening for STDs and cervical cancer.

In addition, given the potential risk of HIV/AIDS transmission among this population, there should be far greater reliance on distributing condoms in a variety of nonmedical settings, working toward eliminating barriers to their use. Special outreach efforts to those women and men at highest risk of pregnancy and HIV transmission must have increasing priority for community programs.

Implementing Nonmedical Models

The convener group proposes the following strategies to help communities develop and implement efforts that would allow for nonmedical models for distribution of birth control pills and other forms of contraception. Specific implementation activities are geared to the issues of oral contraceptives and condoms. Key players include health providers, health educators and policymakers.

Health providers and health educators can:

- Change the standard held by the American College of Obstetricians and Gynecologists, Planned Parenthood Federation of America, Federal Title X legislation, state departments of health, and others requiring pelvic examinations before the provision of oral contraceptives.
- Educate public health officials and medical personnel to consider the separation of public health needs (e.g., screening for STDs) from the provision of the contraceptive pill itself.
- Make nonprescription methods of contraception available in nonmedical settings, including community drop-in centers.
- Educate adolescents, parents and guardians and other professionals working with youth on the effectiveness of nonmedical models of contraception.
- Implement and evaluate condom distribution programs. The positive aspects of condom use—in terms of preventing both unintended pregnancies and STDs, including AIDS—need to be widely marketed.
- Work in conjunction with AIDS prevention programs to increase condom distribution and use.
- Develop extensive condom programs in a wide range of alternative distribution sites, such as teen drop-in centers, youth employment programs, etc. Provide instructions, information on the benefits of condom use and free condoms.
- Educate both males and females to purchase, carry and use condoms.

Work in conjunction with AIDS prevention programs to increase condom distribution and use.

Policymakers can:

- Develop waivers for federally funded grantees that allow flexibility in the service delivery model. Examples include counseling without medical services, distributing nonprescription contraceptives without pelvic exams, and referring teens to clinics that provide services, follow-up and programs that serve males.
- Conduct and evaluate pilot projects to assess the medical, social and administrative experiences with nonmedical distribution models (including the provision of oral contraceptives). Based on these demonstrations, disseminate findings and plan future projects that build on these results.
- Increase the role of pharmacists in decreasing the barriers to purchase of nonprescription contraceptive methods. In many sites, condom purchase continues to be extremely difficult and embarrassing for adolescents. One approach is to work at both the national and local level with pharmacists to plan condom displays that are easily accessible to young people. Another approach is to work with companies that distribute condoms to find alternative ways to sell condoms (e.g., through mail order).
- Develop new distribution sites for condoms, including condom vending machines in

shopping malls, movie theaters, restaurants, public bathrooms, bus stations and gas stations.

- Make other nonprescription methods for women (e.g., foam, sponge) available through vending machines, as well.

Continue Support Services for Adolescents

The NRC panel suggests that public support for contraceptive services for adolescents be continued.

Funding issues are critical in meeting the challenge of reducing unintended pregnancy. There must be continued, long–term public support for contraceptive services to adolescents. Such programs should minimize the barriers of cost, convenience and confidentiality. The positive results of community-based family planning programs should be more widely publicized. Overall funding to strengthen reproductive health services aimed at reaching young people at risk of an unintended pregnancy or a sexually transmitted disease should be increased.

Funding for reproductive related services should be a part of an overall commitment to funding health and social services. Often these associated services interact with the adolescent's ability to be an effective contraceptive user. For example, mental health funding directed at teenagers for short-term counseling and care can be considered an integral part of efforts to make adolescents function more effectively in their schools and communities. Other prevention efforts are needed as well, including health education and health promotion activities. Comprehensive health care includes general physical and mental health care; information on adolescent development; reproductive health care information and counseling about abstinence, contraception, abortion and adoption; and the provision of appropriate services.

Teenagers should be provided with information on locating health care services for a wide variety of concerns, including physical or mental health and treatment of STDs. They need to learn how to access health care, what to expect when they seek care, how to set up appointments and how to follow up on referrals. All services should be confidential and free or charged on a sliding scale.

It is important to reexamine health budgets in terms of overall funding directed at adolescents and compare the amount allocated for preventive care to allocation for treatment. Additional funding for adolescent health available through private sources (foundations) or public programs at the federal level (federal Maternal and Child Health Division) must be identified. Technical assistance must be provided, so health providers can apply for these funds.

The Early and Periodic Screening Diagnosis and Treatment Program (EPSDT) under Medicaid is an untapped resource for states who want to provide care to Medicaid eligible adolescents. This aim can be accomplished both though the use of reimbursements for outreach (not currently available under Medicaid) and by establishing more frequent (e.g., annual) reimbursable comprehensive physicals for adolescents. Adolescents' reproductive health needs can be dealt with in a sensitive manner through these general and thorough exams.

National networks must be encouraged to overcome established regulations and the common standards and practices that restrict the advertising of contraceptives.

Sufficient funds should be available to the department of health, family planning services division and any contracting agency for EPSDT to ensure family planning services are available to any adolescent seeking services. Services should: (1) be low cost or free, as well as readily available and accessible to all teens; (2) be confidential; (3) be appropriate for males; and (4) include information about AIDS and other STDs and smoking, alcohol and other drugs, as related to pregnancy.

Other third-party reimbursement channels should be explored as payment mechanisms to enable adolescents to access confidential services. Mechanisms should be established for health maintenance organizations, so young people can receive confidential services without parental notification.

To increase public support for contraceptive services for adolescents, the effects on contraceptive use and unintended pregnancy of paid promotional messages for contraceptives directed at sexually active adolescents should be tested.

As previously discussed, the media are important in shaping the messages young people receive about sexual behavior. National networks must be encouraged to overcome established regulations and the common standards and practices that restrict the advertising of contraceptives. Until that time, media can help by offering young people messages of responsible behavior and by increasing public support for contraceptive services for young people.

Implementing Continued Services

The convener group suggests the following activities to help communities develop strategies that will support the expanded funding of family planning services and increase public commitment to the program. Key players in the implementation of this strategy are direct service providers, policymakers and funders, communities and community agencies and the media.

Providers can:

- Make contraceptive services available to all teenagers at low or no cost.
- Publicize the availability of contraceptive care to teenagers through all media channels.
- Encourage all public programs that serve adolescents to provide reproductive health information and/or services to teenagers. This effort can range from providing referral information on community family planning services (e.g., posters, brochures) to having a local family planning clinic co-locate a health educator or counselor on site several hours per week.
- Organize hot lines to foster communication, referral and crisis intervention with regard to sexuality issues.
- Develop and fund more comprehensive adolescent care centers in hospitals and community health centers that integrate reproductive services as part of the array of services available to young people.
- Integrate clinic services with other health promotion and education efforts, including family life education.

Policymakers and funders can:

- Insure that state policies and programs encourage and strengthen access to confidential contraceptive services for adolescents.
- Expand overall federal funding for family planning counseling and medical services.
- Expand Title X funding of family planning clinics to include a renewed focus on adolescents.
- Include special and additional funding incentives for clinics that provide clinic sessions in a sensitive and confidential manner, at times convenient for adolescents.
- Provide Title X funding to community-based services designed to increase adolescents' access to and use of family planning clinics (e.g., outreach efforts).
- Support the funding of family planning staff located in different community settings and providing services on alternative community sites.
- Provide more extensive state and local funding to support family planning care for teenagers as a viable alternative to the need for abortion care.
- Maximize the use of Medicaid and Title XX funds for third party reimbursements of family planning services.
- Provide technical assistance to community programs to upgrade the quality of reproductive health programs or to initiate new ones.
- Repeal restrictive laws on nonprescription contraceptives.
- Change Medicaid policies that hamper teenagers' confidentiality in receiving care.
- Where they exist, repeal laws restricting the provision of information, prescriptions and services on school grounds.
- Repeal state laws exempting school health employees from privileged communication protections.

• Require all state Medicaid programs to provide cards to all recipients in a family, especially adolescents, offering youth greater access to health care services.

• Provide incentives, including tax credits, for interagency and cooperative efforts between the private and public sectors in establishing a coordinated network of services to integrate confidential reproductive services for adolescents.

• Allocate necessary public and private funding that will enable counties with high teen pregnancy rates to be first in implementing prevention strategies.

Communities and community agencies can:

• Insure that community-based health and youth-serving agencies make information on contraceptive care available to all their sexually active clients.

• Establish formal linkages, including interagency agreements, with health serving agencies to facilitate the cross-referral of youth between agencies.

• Consider designating an agency as an alternative distribution site for nonprescription contraceptives, such as foam, condoms and sponges.

• Explore other alternatives, including the co-location of family planning staff on site to assist with health education efforts, counseling and referrals.

• Educate parents and other adults who serve the community (coaches, firefighters, police, school principals) about the importance of contraceptive services for teenagers and what those services are.

• Inform adolescents about health services in their communities and teach them how to be effective health consumers.

• Identify major political donors and inform them about the issue of adolescent pregnancy and pregnancy prevention. Encourage their involvement in contacting and educating elected officials regarding the impact of adolescent pregnancy on their state.

The media can:

• Work in conjunction with service providers to create a media campaign to increase public recognition of the value of family planning services.

• Help increase public acceptance of adolescent contraceptive use by presenting positive role models in television programming. Show teenagers communicating with their families and partners about contraception.

• Fund the development and airing of paid promotional messages to encourage contraceptive use among sexually active teens.

Include Contraceptive Education in FLE

The NRC panel suggests including information on methods of contraception, how to use them and how to obtain them in sex education programs.

Although the majority of adolescents receive some form of sex education before graduating from high school, several surveys of high school teachers and superintendents of large city school districts have documented that the content of sex education courses varies widely across the country (Orr, 1982; Sonenstein and Pittman, 1984). The amount of discretion left to school districts allows for great control at the local level, so school districts select both the content, the amount of FLE that will be taught and where in the curriculum the subject matter will be included.

Given the pattern of earlier sexual initiation among adolescents, it appears that many young people receive FLE after they have started to have sexual relations.

The most recent national study of school teachers across the country indicates that while there has been an increase in the number of school districts providing some form of FLE to their students, a large proportion still do not provide specific information on contraceptive methods or where to obtain a method of

contraception (Forrest and Silverman, 1989). While teachers believe that school sex education courses should cover sexual decision making, abstinence and birth control methods, only 82-84% of teachers provide instruction in these topics. The largest gap appeared between what teachers believed should be taught about sources of family planning care and what was actually taught. While 97% of teachers state that sex education courses should identify where students can obtain a method of contraception, only 48% of teachers are teaching in schools where this information is made available.

In addition, while teachers believed that FLE should be taught by grades 7 or 8 at the latest, the majority of courses are still not taught until the 9th or 10th grades. Given the pattern of earlier sexual initiation among adolescents, it appears that many young people receive FLE after they have started to have sexual relations. The study also documented that the actual time devoted to teaching about birth control methods, not including abstinence, averaged one hour in the 7th grade, increasing to a total of 2.7 hours in the 12th grade. The overall time devoted to the teaching of FLE varied depending on when it was taught, ranging from 11.7 hours in the 7th grade to 18.3 hours in the 12th grade (Forrest and Silverman, 1989).

While the majority of respondents (72%) had attended a workshop, conference or seminar designed to help them teach FLE, these same teachers often have major gaps in their own knowledge about contraceptive effectiveness and the risks associated with specific methods of contraception. While many may discuss the pros and cons of available birth control methods (83%) and how each method works (74%), far fewer discuss how to use each method of contraception (67%) (Forrest and Silverman, 1989).

The study documents that many of these teachers still do not have teaching materials readily available to assist them. The majority indicated that they need additional assistance with factual information, teaching materials or teaching strategies regarding abstinence, birth control, AIDS and other STDs. While there is wide support for teaching sex education, many of these teachers report that they often feel external pressure from parents, the community or the school administration not to teach about birth control, condom use, abortion, homosexuality and safer sex practices.

Implementing Contraceptive Education

The convener group proposes the following activities to help communities develop and implement sex education programs that incorporate information on contraceptives. Key actors in implementing the recommendations include family life educators and community agencies.

Family life educators can:

- Include contraceptive information in all FLE curriculum.
- Disseminate educational materials that present clear and easily understood information on the methods of contraception.
- Provide indepth training for sex and family life education teachers in the area of contraceptive care.
- Integrate accurate information on safety issues of the contraceptive pill into existing family life and sexuality education programs.
- Work with communities to introduce FLE earlier in the school curriculum (before the 8th grade).

Communities and community youth-serving agencies can:

- Use health service providers as resource persons in classrooms and in other sites serving youth.
- Work with FLE programs and other community resources to implement on-site FLE programs, including a component on contraception.
- Use media to provide additional sex education information, particularly information to correct widely believed contraceptive myths.

Offer a Variety of Service Models

The NRC panel also concluded that a variety of contraceptive service models should be used to reach adolescents, including efforts that support adolescents in the decision to abstain from sexual activity.

Making family planning services accessible

to adolescents requires a reexamination of the way that services are currently being delivered to them. Even terms such as family planning and reproductive services appear to alienate young people who do not consider that these services are pertinent to them.

Accessible, affordable, comprehensive and coordinated health care for teenagers is an important service component in the primary prevention of adolescent pregnancy. Health services must emphasize wellness education and should incorporate full psychosocial histories and records of risk-taking behaviors as part of the comprehensive assessment and treatment services provided.

Given the variety of psychological and logistical barriers to care, it is important to reconsider how clinics can meet adolescents "where they are" without relying solely on the more traditional clinic approaches. Thus, clinics need the financial support to develop alternative sites where care can be provided on a drop-in basis. For example, several innovative family planning clinics operate in store-front sites in shopping malls where young people tend to congregate.

Family planning program managers should reexamine their programs and assess the use of funding and staff. Managers should be supported in efforts to be creative with currently available funding and open to the modifications and changes that may emerge. For example, management level technical assistance should be made available on a periodic basis to review whether reallocation of funding and/or staffing will make the program more accessible to an adolescent population.

Changes in service delivery also include changes in the amount and kind of counseling and education available to young people. A stronger focus on implementing behavioral change requires a shift to behaviorally oriented counseling techniques that emphasize skill development, interpersonal communication skills and specific techniques for incorporating lifestyle changes, including the integration of contraceptive methods in the sexual relationship. This requires empowering adolescents, particularly young women, to be assertive about their rights within the sexual relationship, including the consistent use of contraceptives.

A more personalized and established relationship between caregiver and client appears to be needed when contraceptive compliance and consistency are expected. The counseling needs of a 14 year old are quite different from those of a 25 year old in regards to contraceptive care.

In addition, innovative efforts to link the non-clinic referring site to the clinic have been shown to increase the likelihood that adolescents will seek the care they need. Thus, if the same counselor who works in a clinic is also located on a school or other community site, there is an increased chance that adolescents will complete the referral, because they know they will see the same person at the clinic site (Zabin, Hirsch and Smith, 1986). It is also imperative that we recognize the need for research to develop new contraceptive methods that may be more appropriate for adolescents.

Several innovative family planning clinics operate in store-front sites in shopping malls where young people tend to congregate.

Comprehensive health and social service programs should be developed that offer counseling for abstinence from the onset of adolescence, contraceptive services for all sexually active youth and special services for out-of-school youth. These special efforts are needed because many youth experience an average of a year's delay between the onset of sexual activity and contraceptive use. Approximately half of all youth experience a pregnancy within 6 months of their sexual debut (Zabin, Kantner and Zelnik, 1979). Follow-up of clinic patients should occur on an ongoing basis to reinforce effective contraceptive compliance.

Innovative programs should be evaluated. Those found to be effective should establish more channels for the dissemination of information. Part of the challenge in replicating

successful programs is the necessity for the kinds of information that go beyond the mere recitation of program components. Specific consultation and technical assistance can help other communities learn how to adapt the model programs appropriately to their own sites and how to meet the specific needs of their communities. Thus, support for trainings and consultations are a necessary part of successful dissemination.

There are a few clearinghouses for written materials and information. These include the Family Life Information Exchange funded by the federal government; Link-Line, supported through Planned Parenthood; and Sex Information and Education Council of the U.S. (SIECUS). However, a separate effort is needed to make program management and implementation information more accessible for other care providers.

An important aspect of the replication process is the need to avoid dilution of the original model, which often occurs when short-cuts are taken. Both private and public funders need to support the successful replication of the original innovative models they have initially funded. Competition for funding often interferes with sharing information and ideas to improve current service delivery models. Many innovative programs receive funding for a limited time, which prevents them from fully demonstrating the impact of the programs. This lack of stable funding severely limits the continued operation of programs.

Implementing Service Models

The following activities can help communities implement a variety of contraceptive service delivery models. Key players are policymakers, family planning providers and teenagers themselves.

Policymakers can:

- Increase federal maternal and child health funding of outreach services to adolescents and encourage innovative programs.
- Provide state and federal funding for coordination and delivery of statewide health programs for adolescents. This includes primary care, mental health services, substance abuse services, family planning education and services, health education, interagency coordination and teen referral information.
- Offer reimbursement for outreach and indepth counseling. Grant formulas should take into account the expense of these services.
- Provide more readily accessible data to local family planning programs as a means of monitoring the delivery of services at the local level.
- Provide funds for the evaluation of clinic services, including the short-term impact on contraceptive compliance and the longterm impact on pregnancy rates. Additional cost studies should also be supported.

Family planning providers can:

- Develop a network of satellite facilities, where young people can get information, counseling and nonprescription contraceptives. Ideally, these satellites should be multiservice centers. One of the main goals should be to encourage teenagers to go to a clinic or doctor as soon as they feel comfortable doing so, with the understanding that in the interim they will be using nonprescription contraceptives.
- Develop models that encourage parental involvement, while protecting the confidentiality of the clinic-patient relationship.
- Develop strong clinic community advisory boards comprised of parents, adolescents, community representatives and providers.
- Enhance outreach efforts to encourage earlier use of contraceptive methods by adolescents.
- Develop improved techniques to provide instructions to family planning patients about the use of contraceptive methods, including the relative health risks of different methods.
- Upgrade the quality of counseling of clinic patients, using innovative approaches such as contract or contingency counseling, insuring a greater commitment to contraceptive compliance by the patient.
- Provide follow-up appointments in which coaching activities can be provided until regular use of contraceptives is established on a sustained basis.
- Provide vouchers for free family planning services for adolescents to enhance referral follow up.

- Expand outreach and educational efforts to include potential contraceptive users.
- Urge the earlier adoption of contraceptives, including use at the onset of sexual relationships.

Adolescents can:

- Play an active role in reviewing programs, so their input can be incorporated in the planning of services.
- Be involved in providing correct information to their peers.
- Participate in peer advocate programs sponsored by family planning programs.

Develop School-Based Models

The NRC encourages school systems, in cooperation with various health care and youth-serving agencies, to further develop and refine comprehensive, integrated school-based service models, including school-based clinics, for implementation in schools with large, high-risk populations.

As communities begin to confront a number of adolescent health and social problems and find alternative ways to respond to these needs, school settings are providing a greater range of services than their primary educational mandate. The school-based clinic has received wide attention as a way to provide comprehensive health care to adolescents. Clinics help establish networks with existing community-based resources and followup to assure that students have received care.

School-based clinics are primary health care centers located on the grounds of junior and senior high schools. Staffed by multidisciplinary teams of professionals led by nurse practitioners and/or physicians, they are typically administered by hospitals, community health organizations and nonprofit agencies. Health services include treatment for minor injuries and illnesses, sports physicals, immunizations, first aid and acute care, laboratory and diagnostic screenings, health education and counseling (including mental health counseling) and drugs and alcohol education and counseling, as well as services pertaining to sexual decision making.

Approximately 15% of clinics dispense contraceptives on campus, while the majority provide either a prescription for contraceptives or referral to community family planning clinics. Services related to family planning account for 10-20% of all clinic visits. A recent evaluation of 6 school-based health clinics demonstrated that the presence of a school-based health center does not hasten the initiation of sexual intercourse or increase its frequency among sexually active students.

At 2 of the 6 sites, significantly more students in the clinic school samples than in the nonclinic school samples used some type of contraception at last intercourse (Kirby and Waszak, 1989). The difference was primarily the result of increased condom use and to a lesser extent, birth control pill use. While neither of the 2 clinics dispensed contraceptives on the school site, 1 of the clinics provided vouchers for free contraceptives at a nearby family planning clinic, while the other clinic provided contraceptive counseling and referrals. At both clinic sites, special education and outreach efforts were made to provide contraceptive education throughout the school, apart from the efforts provided at the actual clinic site. Overall, there were no differences among students at the clinic and nonclinic schools at any of the 6 sites as to whether they had been pregnant or gotten someone pregnant within the last 12 months (Kirby and Waszak, 1989).

Advocates for family planning services face major barriers in creating a climate of acceptance for responsible contraceptive behavior.

Other variations on the school-based health clinic model have also emerged. For example, one model program linked a junior and senior high with a storefront clinic in Baltimore and placed both a nurse practitioner and social worker approximately half time in each school

site during school hours. After school, these same staff members were available for medical care appointments and additional counseling and education. Unlike comprehensive school-based centers, this program focused primarily on family planning and reproductive health related services. Program results indicate that the program was successful in decreasing adolescent pregnancy rates by 30%, as compared to an increase of 58% in control schools (Zabin, Hirsch and Smith, 1986).

Another model variation combines the services of a comprehensive school-based clinic site with other services, including employment counseling, recreation programs and additional counseling services. This model is currently being tested throughout the state of New Jersey. It is funded by a special state initiative in each of New Jersey's counties. While the majority of sites continue to be school sites, a number of recreation sites or youth centers near schools are used. The focus of this effort extends far beyond issues of adolescent pregnancy prevention to a special focus on high-risk behaviors among adolescents.

Implementing School-Linked Services

The following activities can help communities develop and implement strategies aimed at providing comprehensive school-linked services. Key actors include funders, health providers, community agency coalitions and school systems.

Funders:

An important issue in implementing programs relates to the need for continued and stable funding of programs. Many of the original school-based health centers were initially funded with the support of private foundations. Although there is currently no specific federal program designated to support school-linked services, a number of communities have utilized Maternal and Child Health block grant funds (Title V) and Community Health Center funding to initiate and develop school-based health services. A number of states, including Oregon, Michigan, Connecticut and Illinois, have taken the initiative to develop school-based health services, using a combination of state tax funds and federal block grant funding to support the effort.

The success of these programs, however, will require additional sources of state and federal support. It is key to recognize that these comprehensive efforts incorporate the issue of adolescent pregnancy prevention within the broader context of adolescent health. For example, many of these programs are geared to providing mental health counseling as well as substance abuse prevention and treatment. Seen within the totality of adolescent health, multipronged funding and program approaches are needed.

In addition to funding in the health arena, it is important to utilize special education funds geared to reach the at-risk adolescent who requires additional psychological support and case management services to continue with education. Again, these support services may have wide repercussions for helping young people deal with a number of high-risk behaviors. These services should be funded both at the school site and off-site to reach those young people who have already dropped out of school.

It is also important to encourage school districts and health and social service agencies to review their current staff responsibilities and assess the possibility of relocating staff, so salaried staff can be used in alternative sites to the traditional clinic site. Co-location of staff at the school site can be a cost-effective approach for reallocating currently available funding. Additionally, community agencies need to explore the feasibility of jointly funding a number of staff, so even small amounts of funding can be combined to create the support of a full-time staff member.

Beyond funders, key actors in implementing school-site models include health providers who are part of community-wide agency coalitions, and school systems.

Health providers and community agency coalitions can:

- Work together to develop a community-wide coalition that includes school representatives concerned with adolescent health issues and pregnancy prevention.
- Help local school districts identify the most pressing social and health problems

impacting local students.

- Document a variety of school-based or school-linked service models that integrate reproductive services with other educational, counseling, social and health services appropriate for their setting.
- Work toward bringing outside health and youth service agencies into schools to organize and implement multiservice programs.
- Identify potential sources of funding for school-based and school-linked services, and write joint proposals with local school districts.
- Explore the possibility of co-locating health and social service agency staff in a variety of school settings to facilitate identification and referral of adolescents at risk.
- Train school personnel (e.g., counselors, coaches, nurses) in counseling and referral techniques, in the absence of a school-based clinic.

Coach adolescents on ways to seek care from a variety of community agencies...

- Seek funds for school-based primary services, comprehensive adolescent health units in hospitals and health centers and free-standing community-based adolescent health facilities.
- Coach adolescents on ways to seek care from a variety of community agencies, including family planning clinics. Teach them, for example, how to identify which agency they need, how to set up an appointment, how to pay for services, how to complete medical forms, etc.

School systems can:

- Develop and implement linkages with comprehensive health programs, so an array of services can be made available to junior and senior high school students either directly on campus or by referral.
- Develop peer education programs, both on and off campuses, for which teens have received training in communication skills, adolescent health issues (including reproductive health) and ways to link peers with community programs.
- Identify sources of additional funding for use with other funding channels to create enhanced on-site services. An example might be school dropout prevention funding.
- Develop resource information packets for students that include health and social services community resources.
- Involve adolescents and their parents in developing comprehensive school-based or school-linked services.
- Assess the possibility of developing support services for parents.

Barriers to Implementation

A number of barriers exist to implementing the recommendations for increasing contraceptive use by sexually active adolescents. Recognizing the somewhat controversial nature of this recommendation, family planning advocates have had to adopt a more timid stance in their efforts.

Advocating for family planning services in general, and for adolescents in particular, often increases American ambivalence toward sexuality for all ages. Contraception and contraceptive services become the lightning rod for those who argue that the availability of contraception has contributed to many of the social ills experienced in American society.

Against this background, advocates for family planning services face major barriers in creating a climate of acceptance for responsible contraceptive behavior. Contraceptive services, and the public funding for these programs, remain controversial in the current political environment.

It is more comfortable for communities and parents to focus on abstinence than to work with sexually active adolescents to increase their access to contraceptive care. Consequently, the fear of focusing on contraception may preclude implementation of these recom-

mendations. This fear, combined with the sexual illiteracy of many adolescents, parents, teachers and other community members, may lead to resistance to the recommendations.

Adolescents themselves appear to experience a number of barriers. Schools may be endowed with moral authority that resists providing information to adolescents, particularly in the area of access to contraceptive care. This deeply rooted historical identity may be difficult to overcome and can create barriers to educational efforts.

In addition, some schools may be in conflict with parents over confidential referrals for offsite care, including contraceptive care. Generally, when a young person needs a referral, the referral is given to the parents, particularly when teenagers need nonemergency health services. The controversy surrounding contraceptive care may make it difficult for schools to provide confidential referrals to teens. In the majority of communities, however, adolescents can access care without parental consent if they seek it directly from a health care provider. Most communities also allow minors to receive substance abuse services, mental health counseling and family planning care without parental consent.

For the most part, adolescents have relatively few skills to access care. Some of these barriers stem from the lack of comfort adolescents experience in seeking care, as well as the lack of motivation they may feel to delay early childbearing. Other adolescents may feel that the cost of contraceptives is too prohibitive to seek care. In addition, because adolescents fear that their parents would be notified of a contraceptive visit, they may not use the family insurance policy, even if services are fully covered. Thus, third-party insurance reimbursement will most likely be of limited use in paying for contraception for adolescents.

Overcoming Barriers

A number of specific strategies can be used to overcome these barriers. Family planning services should be considered a key component in efforts to decrease the incidence of adolescent pregnancy.

Constituency building at the local, state and national levels can help family planning providers gain greater acceptance of their programs. Many health concerns overlap. For example, coalitions focused on maternal and child health issues—such as infant mortality and increasing access to prenatal care through national insurance—have long recognized the need for access to family planning services, both before conception and postnatally. In other coalitions, such as those concerned with employment, housing and education, the interrelationships with reproductive services have not been as fully explored, possibly because these connections need to be clarified for participants. Previous efforts should also be reexamined for successes, as well as renewed campaigns.

Even in coalitions where there are strong overlapping concerns, such as the environment, stronger efforts can be made to join different constituencies. A notable example has been the National Geographic Society, which has recently made strong policy statements on the interrelationships between population control and environmental protection and has pledged to work toward both goals.

Careful groundwork is needed to allow advocates to make the risk of doing nothing clear to decision makers on a very specific basis. For example, when dealing with legislators in efforts to allocate funding for programs, advocates need data (e.g., the number of teenage pregnancies, abortions and births, the cost of neonatal intensive care given the likelihood of complications, etc.) by district to demonstrate to policymakers why they should support family planning services.

Similarly grounded approaches are needed when dealing with public officials at all levels in health and social service agencies that can help sponsor and or implement health care initiatives. The Department of Health should analyze the impact of current contraceptive health services and ways to improve access to accurate information and comprehensive health care, particularly for uninsured youth.

Supporters of adolescent access to family

planning care must be willing to face controversy (and use it as an ally) and must also respect the legitimacy of the opposition's views. It is also important to develop active coalitions to support access to contraceptive care and create a social climate where successful contraceptive use becomes a social norm. In turn, successful contraceptive use would decrease the need for a large number of abortions.

Individual agencies and their constituents most concerned with the issue must organize themselves and their communities to affect legislation and public policy formation. To be most effective, organized training in the political process is required at both the state and local levels for individuals and communities concerned with preventing the problem of adolescent pregnancy.

Officials seeking elected positions at all levels must be sensitive and well informed on the issue of adolescent pregnancy postponement. We must make pregnancy prevention a priority. It is important to conduct public education campaigns to increase awareness of the cost of the problem. Statewide plans for providing comprehensive health care for teenagers, including reproductive health services, should be implemented.

National and local funders should be encouraged to support this NRC recommendation. Local and national foundations, as well as the private business sector, should be advised of the economic impact of adolescent health—and in particular, reproductive health—in an effort to gain greater financial commitment from them.

For example, United Way agencies should be educated at the local and national level to provide adolescents with access to comprehensive health care (including general physical care, information on adolescent development, reproductive health care information and counseling about abstinence, contraception, abortion and adoption) and appropriate services.

Ways should be found to commit financial and political support to primary prevention efforts, including FLE that stresses abstinence, as well as access to reproductive health care. Throughout these educational campaigns, adolescents should be taught sexual negotiation skills to enable them to adopt abstinence or responsible contraceptive behavior if they are sexually active. Credible spokespersons should be identified, and opportunities created for them to publicize the message. The necessity of involving both partners in sharing responsibility for sexual activity, reproduction and parenting should be stressed.

Another major strategy is to decrease the categorical nature of family planning services, especially for youth, and increase the availability of health care delivery models that provide comprehensive health care services to adolescents, including fertility related services. Limited funding for these services will require that many communities develop interagency approaches to meet the health care needs of adolescents in a confidential manner.

Both interagency and intra-agency coordination of state and county agencies directly impacting adolescents should be mandated. Local communities and counties should develop comprehensive community plans that address prevention efforts at the local level. Teenagers, parents and a broad-based group of professionals should be involved in formulating the plans, so they reflect community values, including diverse cultural backgrounds. The issue of contraceptive information from a multicultural perspective should be considered, as well as the complex relationship that exists between each community and its concerns regarding the use of birth control.

Potential sources of funding (federal, state, county, private foundations and industry) that can be used for adolescent pregnancy postponement should be indentified. Funding partnerships between a variety of sources should be facilitated. State agencies that currently administer programs and allocate monies to improve coordination should be identified and worked with.

Agencies should receive sufficient resources and assign key staff to accomplish coordination, and they should also be rewarded by demonstrating successful interagency cooperation. All state agencies should be required to coordinate funding on the state and local levels to support the goals of pregnancy postponement through the effective use of contraceptives. ❑

Reasons to Wait: Enhancing Life Options

Adolescents need a reason to believe that parenthood is inappropriate at that time of their lives and that their opportunities for personal and occupational success will be improved by postponing pregnancy. The NRC panel suggests that adolescent fertility can be indirectly reduced by nurturing the motivation to prevent untimely and unplanned parenthood.

A significant evolution took place in the field of adolescent pregnancy prevention when it began to focus on an important part of the pregnancy prevention equation—increasing the motivation of young people to delay an initial pregnancy. Perhaps this reflected a recognition that providing family life education and increased access to contraceptive care would be insufficient to resolve the overall problem of unintended adolescent pregnancy.

A significant evolution took place in the field of adolescent pregnancy prevention when it began to focus on...increasing the motivation of young people to delay an initial teenage pregnancy.

Health professionals have long recognized the relation of social factors such as poverty, unemployment and education to health care outcomes. However, categorical funding approaches and professional discipline backgrounds have often resulted in increasing barriers among those professionals most committed to youth development. As these professionals became increasingly aware of the complexity of the problem of adolescent pregnancy, new comprehensive approaches to prevention have emerged that extend far beyond the public health solutions of the past.

There are two principles underlying the new effort. First, one must understand adolescent pregnancy and parenting in terms of life options available to adolescents. Then one can work toward empowering adolescents to make conscious choices—choices about their sexuality and reproduction in particular, but also about their personal relationships, health, education and financial futures. Family, religious organizations, community organizations, public agencies and private business must be partners in this endeavor.

Past prevention strategies (which continue to shape most current efforts) typically combined a medical and public health model that made contraceptives and birth control information more accessible to teenagers. Once adolescents were armed with adequate information and services, it was reasoned, they would be motivated to take precautions.

Comprehensive approaches are being tried in a variety of settings, but many programs tend still to seek and promote a single approach as the answer to teenage sexuality. In fact, no one approach can reach all segments of the adolescent population. Community-based prevention programs involve several organizations that are willing to coalesce around this issue.

Combined efforts produce greater efficiency in the use of currently available community

resources; create links among a variety of concerned groups such as parents, service clubs, businesses, foundations, religious organizations, clinics and social service agencies; bring greater coordination of service delivery to clients; create a strong sense of identity and a solid funding base; increase the level of professionalism; and provide shared management and evaluation systems (Brindis and Jeremy, 1988).

Treating the Causes

Adolescent pregnancy is an indicator of a nation's well-being. A high rate of teenage pregnancy and childbearing is a symptom of major social and economic ills. The symptom itself can be treated in isolation with limited success, but no cure can be expected unless underlying causes—such as poverty, isolation, low self-esteem and lack of hope for the future—are identified and treated.

Major coordinated efforts at many levels of intervention are needed to attack the problem. These efforts must be aimed not only at the teenagers themselves, but also at the political, economic, medical, education and religious institutions whose policies affect teenage pregnancy indirectly, but nevertheless strongly. The basic challenge to those who want to help adolescents avoid the consequences of premature parenthood is to develop a coordinated network of public and private services.

Local, state and national officials play a central role in facilitating the necessary coordination. Policies established by these leaders in education, health, job training and social services directly influence the availability and effectiveness of services to teenagers at risk.

The absence of strong support for abstinence and the lack of family planning services are important reasons for the high U.S. adolescent pregnancy rate, but the causes are more complex than that. The family, the media, peers and religion all influence teenage sexual behavior. There also appears to be a constellation of risk-taking behaviors adopted by teenagers that includes early sexual activity, drug and alcohol abuse and dropping out of school. These behaviors cannot be classified as either cause or effect; they are interrelated, which means that adolescent pregnancy prevention efforts must expand their focus to include other aspects of adolescent development.

We should also recognize that many adolescents engage in early sexual activity without engaging in other high-risk behaviors. However, many of these teenagers are so lacking in aspirations for their lives that warnings about the risks of early childbearing to their futures have no effect. They see their futures as so bleak that a pregnancy is not perceived as something negative. On the contrary, they see a child as something to relieve the bleakness (Pittman, 1985).

A Lack of Hope

Lack of hope appears to be a major antecedent factor in adolescent pregnancy. This lack of hope may be reflected in the tripling of adolescent suicide rates over the last 20 years (Kovar, 1986). A sense of limited economic and educational options, combined with the difficulty of postponing gratification, is translated into substance abuse and sexual activity, which offer immediate gratification.

Research indicates that poor self-esteem, a lack of hope for and confidence in the future, a sense of limited opportunities and perceptions of a life without economic security differentiate pregnant teenagers from those who delay sex or use contraceptives consistently (Pittman, 1986a). Teenagers from poor families do not believe they have educational or career opportunities, so pregnancy does not cause the fear of forfeited opportunity that a middle-class adolescent feels.

Dropout prevention efforts can be considered primary pregnancy postponement, because many teenagers become pregnant after dropping out of school. Although it has long

been thought that girls drop out of school because they are pregnant, recent analyses show that many girls who become mothers drop out prior to pregnancy. Data from the national High School and Beyond Study (Pittman, 1986b) showed that of all those girls who both dropped out and had a child, 28% had dropped out prior to conception.

A survey of never-married women in their 20s showed that among those who had been both pregnant and school dropouts, 61% of the pregnancies occurred after dropping out of school; a survey of very young welfare mothers showed that 20% were already out of school before conception (Dryfoos, 1987). A principal reason for dropping out of school given by both sexes is school itself—its perceived irrelevance to their needs and their poor academic achievement.

Many materials continue to enforce traditional gender role stereotypes of woman-homemaker and man-professional, giving girls the impression that they have fewer opportunities than their male peers.

The National Longitudinal Survey of Youth, also cited by Pittman (1986b), found significant differences by race. When female dropouts were asked the primary reason for leaving school, 41% of Blacks, 15% of Hispanics and 14% of Whites said pregnancy; another 4% of Blacks, 15% of Hispanics and 15% of Whites said marriage. School-related reasons were primary for 29% of Blacks, 21% of Hispanics and 36% of Whites.

These 2 national surveys have also produced substantial evidence about the association between school achievement and childbearing. The High School and Beyond Study, looking at each ethnic group separately, found that White, Black and Hispanic sophomores with low academic ability (in the lowest third of their class) were twice as likely to become unwed parents by their senior year as those students with high academic ability (Morrison, 1985). The National Longitudinal Survey of Youth found that females in the bottom 20% of basic reading and math skills were 5 times more likely to become mothers over a 2-year period than those in the top 20%.

Some researchers suggest that girls' poor academic achievement and their sense that school is irrelevant to their needs is at least partially attributable to the treatment they receive in the educational system. Recent studies show that both male and female teachers have different expectations of their students based on sex.

Teachers are likely to give girls less attention than boys; to direct rote memorization questions at girls, but to encourage independent thinking in boys by asking them complex, open-ended questions; to reprimand girls for speaking out of turn, but to tolerate this behavior in boys; and to offer girls less substantive evaluations of their work than boys (neatness of handwriting versus quality of content) (de Nys and Wolfe, 1985).

In addition, educational materials such as books, films and displays continue to highlight male achievement throughout history and ignore women's accomplishments. Many materials continue to enforce traditional gender role stereotypes of woman-homemaker and man-professional, giving girls the impression that they have fewer opportunities than their male peers. Combine these experiences with those of poverty, racial discrimination and low parental educational level, and girls may be inclined to see pregnancy and parenting as one of the most attractive options for the future (Brindis and Jeremy, 1988).

School failure is a crucial factor in the risk pathways that adolescents face—and if that failure occurs at a very early age, other negative events also take place.

The High School and Beyond Study documents the relationship between school dropout, adolescent pregnancy and lack of economic opportunity for young people during and after their high school years. Among the study's

findings are the following:

– Nongraduate females, married or not, are 6 times as likely as graduate females to have children.

– Nongraduate females are 9 times as likely as high school graduate females to be on welfare.

– Nongraduates are at least 4 times as likely as graduates to engage in unlawful behavior.

– Graduates are more likely than nongraduates to be working or enrolled in post-high school education or training or serving in the armed forces, while nongraduates are more likely to be unemployed and looking for work.

Knowledge, Skills and Options

Emerging themes in the field of adolescent pregnancy postponement cluster around 2 concepts: increasing the life options available to young people and increasing their capacity to make decisions. Life option approaches are differentiated from capacity-building approaches. Capacity implies having the knowledge and skills required to prevent unintended childbearing—including sex and family life education, support for abstinence, access to birth control services if an adolescent is sexually active and availability of abortion services as a backup to contraceptive failure.

Life option interventions provide the rationale for postponing pregnancy. Interventions also teach the skills necessary for completing an education and entering the labor force and choosing alternatives to early motherhood. Strategies include school enhancement, dropout prevention, individual counseling and support, job training and job placement (Dryfoos, 1986).

Although life option interventions may not specifically focus on pregnancy postponement, their contribution to the adolescent's self-esteem and aspirations may have an indirect effect on it. For example, school enrichment, truancy and dropout prevention programs, vocational guidance, job skill training and placement, psychological services and recreational programs all alleviate conditions that contribute to adolescent childbearing. These services are as important for adolescents who have not initiated sexual activity as for those who are already teenage parents and are trying to delay the birth of a second child.

Many disadvantaged youths say they have nothing to lose by becoming parents. They feel no door will be closed by early pregnancy and parenting because they believe from the onset that no doors are open to them. The belief among young people that there is a positive, attainable future worth planning and preparing for—that they have promising life options—is a powerful and necessary element of adolescent pregnancy postponement (Pittman, 1986b).

As in all prevention efforts, an important theme for the future is the need for multipronged approaches to solve this extremely complicated, multifaceted problem. Bringing together an array of agencies and programs to share their efforts and resources will enable communities to develop more targeted approaches to meeting the specific needs of adolescents at various points in their lives.

Strategies for Enhancing Life Options

The NRC panel's suggestions for strategies to implement this recommendation are: develop life-planning courses, develop programs to improve school performance, develop employment programs and develop programs to provide role models for high-risk youth.

Develop Life-Planning Courses

The NRC panel recommends that life-planning courses should be developed, implemented and evaluated in a variety of settings.

Life option programs may be further enhanced by incorporating FLE and access to birth

control. Traditionally, schools have been important partners in the merging of capacity-building and life option interventions. In several sites, family life education is now being joined with vocational education and emerging as life planning, with a strong message that if teenagers want to achieve their career goals, they must delay childbearing.

Current efforts to help communities develop meaningful interventions include parental involvement programs, peer counseling programs, formal referral mechanisms to community clinics and services, and school-linked services. Many youth agencies, such as the Girls Clubs, Boys Clubs, YWCA, 4-H, Girl Scouts and Boy Scouts, have committed themselves to developing pregnancy prevention programs at the local level and to working within the broad national coalition to advocate for legislation in this area.

Because teenage pregnancy is not a single problem, effective intervention strategies must be multifaceted. Different groups of teenagers may require various messages, outreach and program approaches. Cultural, gender and age differences have to be taken into account when designing these strategies (Pittman, 1986a). An ideal strategy would combine several adolescent pregnancy prevention models. Adolescents at highest risk of pregnancy may need a case manager, a continuous counselor or an advocate who provides counseling and brokerage of services.

Because teenage pregnancy is not a single problem, effective intervention strategies must be multifaceted.

Implementing Life-Planning Courses

The convener group suggests the following activities to help communities develop and implement life-planning courses. The key players are school and community educators, policymakers, program managers and funders.

School and community educators can:

- Implement life-planning curricula that demonstrate how early childbearing creates a barrier to educational and other areas of achievement.
- Address multiple life-planning issues—such as school achievement, substance abuse and delinquency—as well as pregnancy.
- Adapt life-planning curricula for targeted populations, including students in the elementary and middle school, or specially targeted adolescents, such as minority youth.
- Encourage religious, civic and youth-serving organizations to offer life-planning courses, particularly where school programs fail to provide this education. Even when a school program is in place, the educational message to teens about developing viable life options should be reinforced in multiple sites from a wide variety of community sources.

Policymakers and program managers can:

- Assist schools in implementing life-planning curricula.
- Review current life-planning curricula and modify as necessary, using a panel composed of community, government and private businesses. Educators should be sensitive to the need to adapt available materials to the special needs of their communities.
- Provide teachers with indepth training to provide comprehensive curricula, and continue supervision if possible.
- Monitor and evaluate existing family life and life-planning courses to determine their success in increasing young people's skills in these areas.
- Incorporate life-planning courses into programs that already reach youth, and engage youth in activities that help build their education and employment skills.
- Provide technical assistance at the state and federal level. Get assistance from teen pregnancy prevention organizations and other community groups to support these activities. Whether funded by government agencies and/or the private sector, technical assistance could support communities in each of the steps necessary to develop programs, including conducting needs assessments, implementa-

tion of new interventions, and evaluation of ongoing efforts.

Funders can:

- Provide adequate funding to support life-planning programs and the technical assistance needed to develop these programs. While funding is available in some sites that focus on reproductive issues, fewer funds are available for life-planning efforts. With increased funding and focus, programs can be broadened to include both aspects.
- Support well-designed evaluations of life-planning programs.

Develop Performance Improvement Programs

The NRC panel suggests that programs to improve school performance be developed, implemented and evaluated.

Throughout the country, a variety of dropout prevention efforts exist, including alternative educational degree programs and vocational training programs. Thus far, no systematic evaluation has been conducted to assess these programs' impact in providing the alternative life options considered necessary to postpone adolescent births. Because school dropout and pregnancy go hand in hand for many teenagers, the need for effective programs to keep teens in school is crucial.

Schools are beginning to develop active partnerships with other community-based organizations to assist them in meeting the challenges of today's students.

The Summer Training and Education Program (STEP) mentioned earlier is an innovative model that aims to improve the basic skills of disadvantaged youth, retain students in school and prevent teenage pregnancy. The model has been tested in a 5-site national demonstration project that includes an extensive and longterm evaluation component. The program involves remediation in basic skills, a life skills component that includes making decisions about sexuality and paid work experience during 2 consecutive summers.

These work experiences are supported by the federal Summer Youth Employment and Training Program. Students are followed throughout the academic year and provided support and counseling services to help them maintain their progress and remain in school. The program targets youth who are at high risk of school dropout. Eligibility criteria include a recent history of grade retention, performing below grade level in reading or math and living in a low-income family.

The program was started in 1985 by the Public/Private Ventures group in Philadelphia, which has collaborated with educational, employment and training institutions at all 5 sites. The experience with two cohorts shows early successes in impacting the academic goals of the program. Participants improved their math scores and maintained their reading levels; control group members lost ground in both areas. Although students participating in the program demonstrated more knowledge of contraception and sexually related behaviors than the control groups, the program has not been shown to have an impact on reducing pregnancy risk.

Although it will be several years before data will be available to evaluate the longterm objective of stemming the school dropout rate, the program has been successful in reducing summer learning losses that poor youth experience to a far greater degree than their more advantaged peers. Summer learning loss is a contributing factor in school dropout.

To provide additional ways to reach school dropouts, school districts should establish alternative education and work centers that provide vocational training and instruction in basic academic skills to dropouts who have been absent from school for at least 45 days and who are up to 21 years of age (although some programs may serve older students).

Students should be assessed and then placed in the program that seems most appropriate to

their needs. This may be a GED prep course, continuation high school, independent study, adult education program or a Job Training Partnership Act program. State educational funds should be provided for initial planning and for 1 outreach consultant position at each site.

School districts can also establish educational clinics for students who have dropped out of school, with intensive, individualized instruction to prepare them to reenter another educational program. These programs should be made available by local school districts and/or private entities that establish educational clinics where there are no alternative education and work centers.

The following implementation activities need to recognize and overcome the fact that many educators are still not convinced that it is the job of schools to address students' nonacademic needs, even though these needs often impact students' academic experience. Another potential barrier is the feeling that school curriculum is already full and that it may be difficult to enlarge the curriculum, particularly for nonacademic materials.

No matter what strategies are adopted for postponement or for the provision of services for adolescents, schools will play an integral and central role, developing competency in basic skills and bolstering students' sense of achievement. Although many educational programs are not directly labeled adolescent pregnancy postponement programs, the strong emphasis on school continuation and the support they provide help give students the motivation and encouragement to continue their education.

Throughout the country schools are beginning to develop active partnerships with other community-based organizations to assist them in meeting the challenges of today's students. Key ingredients for collaboration appear to be continuity of care, coordination and comprehensiveness of services. Through joint partnerships special targeting of at-risk adolescents can be instituted.

Collaboration between students, parents, schools and service agencies affords greater opportunities to meet the varying needs of all students. It also allows greater flexibility in delivering services to young people and provides the opportunity to integrate health education, preventive health services and counseling into the student's educational world.

Improving educational outcomes for all adolescents and responding to their special needs is imperative. The overall goal is for every teenager to graduate from high school with the skills needed to obtain gainful and meaningful employment and/or further education. All students should have access to an indepth, enriched core curriculum to facilitate their entry into the world of work.

Collaboration between students, parents, schools and service agencies affords greater opportunities to meet the varying needs of all students.

Implementing Performance Programs

The convener group proposed the following activities to help communities develop and implement programs aimed at improving school performance. The key players are funders, policymakers, educators and educational systems.

Funders and policymakers:

The role of funders and policymakers in the educational arena is of paramount importance. Beyond the development and implementation of innovative model programs, major educational policy reforms are needed throughout the system of education.

Adequate funding, including the expansion of Chapter 1 funds at the federal level, should be made available for improving the educational environment. Funds should also be made available to community groups who work closely with schools to improve the educational experience and educational outcomes for young people. The central mission of educating youth in basic academic skills should be improved for all.

Reforms should include making schools smaller, so the amount of individualized attention that students receive is expanded. Middle-grade education should also be restructured to be more responsive to the diversity of needs and learning styles found among young adolescents during the challenging period of transition from elementary to high school.

Help students explore nontraditional career options historically not selected because of gender or racial stereotyping.

Overall, schools should upgrade the quality of teaching basic skills for all children. In addition, students must receive affirming experiences in school. Teachers must be sensitive to minority children's cultural backgrounds and school curriculum must be responsive to both the unique and universal qualities of those cultural backgrounds.

In order to implement new policy reforms, communities need to be organized and empowered to demand that schools be reorganized to more effectively educate their children. While this is a major task, it is a key in reducing not only the incidence of too early parenthood, but in improving the overall quality of life for youth.

Strong collaborative relationships among school personnel, parents and family, neighborhoods and community organizations can help bring the necessary resources and leadership to bear on the problems of disadvantaged youths. Public education campaigns on the relationship between educational enhancement and pregnancy prevention should be targeted to school systems, as well as other policymakers.

Finally, young people need viable economic opportunities, including appropriate opportunities to develop job readiness skills. Business and education sectors must work together to forecast skills that will be needed in the job market and prepare students for their future.

Because educators and educational systems can play an important role in implementing this recommendation, special consideration is needed for the practical steps they can institute.

Educators and educational systems can:

- Develop alternative educational programs with a work experience component or concurrent college and high school enrollment. Alternative methods of education (e.g., GED, vocational classes, independent studies, etc.) may be needed.
- Provide academically challenging courses for all students, with appropriate support for students who need special assistance.
- Help students explore nontraditional career options historically not selected because of gender or racial stereotyping.
- Train teachers to be competent educators who exhibit high expectations for all their students and who are racially sensitive and nonsexist in their approaches.
- Provide smaller classes by hiring additional teachers, so students can benefit from additional teacher contact.
- Provide tutoring opportunities to assure continued academic achievement for all students.
- Make a renewed commitment to providing youth with quality education, regardless of gender and cultural or economic background.
- Enlist the help of young people, parents, schools, religious organizations, businesses, community groups and agencies to develop a team approach to the problem of teenage pregnancy and school dropout.
- Utilize all available public and private sector resources for education, and make it relevant to the student's future.
- Expand the concept of specialized schools that provide special expertise in a specific area of learning. For example, one curriculum can be developed to emphasize health and science, while another might emphasize foreign languages. All students within a school district would have the option of attending the school that would be closest to their interests.
- Emphasize the teaching of problem-solving and decision-making skills throughout the curriculum.

- Establish an individual intervention plan, including school tutoring, counseling, parental involvement, self-esteem building experiences and learning options, depending on students' needs. Provide students with appropriate testing and placement.
- Develop on-site case management services to insure that students receive adequate counseling and are assisted to access other community services as needed. These counselors can assist in vocational, academic and personal decision making. Other specialists, such as psychologists, social workers, therapists and learning specialists, should be available to students on a regular basis as needed, particularly for students at risk of dropping out.
- If more comprehensive case management services are not feasible, increase the quality and availability of counselors in schools by increasing the number of school counselors and teachers who serve a counseling function.
- Develop and sponsor peer counseling programs that include students who may be at risk of school dropout.
- Expand parent outreach programs, and provide information so parents can reinforce educational experiences in the classroom. Special efforts are needed for immigrant families and others who may feel uncomfortable with the school system or educational environment.
- Expand extracurricular activities that occur at the school site, including after-school educational experiences.
- Increase the ability of school systems to monitor, assess and provide remediation to students not achieving in schools.
- Identify and assist students who are falling behind in their academic training in their early years.
- Mobilize local school attendance review boards and establish early warning systems to help identify students beginning a pattern of truancy and to initiate intervention programs.
- Institute dropout prevention programs that include special efforts at the transition points between elementary school, middle school and high school, when many dropouts occur.
- Develop programs with more flexible learning environments that build on students' different cognitive styles to promote academic achievement.
- Expand the number of hours and months that schools are open to accommodate the needs of different students and families.
- Infuse school curriculum with school-to-work transition opportunities.
- Develop community programs to accommodate the needs of dropouts, either through schools or in alternative community-based settings. For example, assist these youth with case management services that include help with homework and other school and personal needs.
- Develop incentive programs for students to stay in school, including increased access to post-high school training and educational opportunities.
- Obtain increased political support and funding for state and local school district efforts at dropout prevention. Make use of improved community awareness of the problem of school dropout to increase political clout for this issue.
- Carefully evaluate demonstration programs targeted at school dropout before the programs are widely replicated.

Although the school dropout rate today is roughly the same as it was 15 years ago, the economy and the skills required in the workplace have changed dramatically.

- Expand the use of professionals representing multiple disciplines in school programs for youth.
- Involve community-based agencies in providing a supportive role for school sites. Individuals can help young people improve their school performance by offering tutoring, remedial and enrichment services.
- Organize after-school and summer programs that provide activities such as recreation,

counseling, health and mental health care linkages, homework assistance and tutoring, academic enrichment, and employment skills training.

- Provide transportation to improve attendance at off-site programs.
- Develop active partnerships among families, the private sector, schools and communities to provide additional resources and opportunities for students. For example, if a business adopts a school, it can help provide specific resources, mentors and job training.
- Provide student support services through schools to help teenagers successfully complete their education.
- Establish interagency cooperation agreements between schools and community agencies concerned with youth issues and encourage the use of the school site to co-locate services.
- Explore collaborative relationships with other community organizations to facilitate co-location of services on school campuses and referral mechanisms to outside agencies. For example, place outreach social workers in junior and senior high schools to provide indepth counseling and support for students as they consider their life options.
- Mandate a statewide core curriculum in sexuality, health education and life skills. With appropriate training in FLE, schools, parents and community groups can expand upon the core curriculum to meet local needs.
- Develop effective data collection systems for each adolescent pregnancy prevention program. Include a monitoring system to follow students as they transfer to different schools and programs. Assess the impact of these programs, and document the reasons students drop out of school.

Develop Employment Programs

The NRC panel recommends that employment programs be developed, implemented and evaluated.

Although the school dropout rate today is roughly the same as it was 15 years ago, the economy and the skills required in the workplace have changed dramatically. Young people who enter the job market with low education and weak basic academic skills face increasingly bleak employment and earnings prospects. These are the same youths at risk of too-early parenthood.

Employment and job opportunities are key indicators of the life options available to young people. Recent research findings indicate that the alarmingly high rate of unemployment among teens from ethnic populations may well be associated with high birthrates. The rapid rise of out-of-wedlock births is a major cause of concern, and there has been insufficient analysis of this phenomenon as it relates to economic opportunities for young people.

Teenage mothers tend to have larger families...than women who begin childbearing later.

Lack of adequate job opportunities at decent wages makes it harder for many young people, particularly young males with limited skills and educational credentials, to get a good start in the job market. This is also true for men in their 20s, the age of many fathers of babies born to adolescents.

The earning power of young males has declined severely over the past decade. The link between these economic realities, the problem of adolescent pregnancy and the increasing rate of out-of-wedlock births should be considered. Recent research by the U.S. Bureau of the Census and the Bureau of Labor Statistics substantiates the relationships among employment, earnings, marriage rates, incomes and poverty rates for young workers and their families (Johnson and Sum, 1987).

Teenage parenthood reduces a young woman's chances of future employment. A national study using census data showed that in 1979, 51.3% of women aged 24 or younger who had children were in the labor force; 36.5% were unemployed. Young women who had not borne children were more likely to be in the labor force and considerably less likely to be

unemployed, with an unemployment rate of 14.1% (Russell, 1980).

The total number of children a teenage mother eventually has is also a major factor in future employment. In a study that tracked teenage mothers, 43% of young mothers with only 1 child had been employed steadily in the last 2 years, as compared to only 10% with more than 1 child (Moore and Burt, 1982).

Teenage mothers tend to have larger families (an average of 1 more child per family) than women who begin childbearing later. Thus, early childbearers must divide whatever they earn among members of a larger family. The probability that a family's income will be below poverty is lowered by 2.5 percentage points for each year childbirth is delayed after the age of 18 (Burt, 1986).

The increasing difficulty in finding affordable childcare as the number of children increases further complicates the employment picture. In another study, 5 years after delivery, 66% of adolescent mothers with 1 child were employed, compared to 29% of women with 2 or more children (Furstenberg, 1981).

Early parenthood is associated with diminished employment success. Women who had their children when still in their teens will not be unemployed; on the contrary, they have a high probability of being employed (Haggerstrom, Blaschke and Kanouse, 1981). However, their employment will most likely consist of the available, low-paying, nonadvancing jobs. And their financial problems will be compounded by larger families.

The lack of viable avenues to self-sufficiency is one of the precursors of adolescent pregnancy. Beginning in schools, young people need to be exposed to the world of work, including special employment related curriculum, career days and field trips. Programs should provide students with the following:

– Goal setting and career options interwoven with educational course choices, including assessment of teen interests and abilities, indepth education about careers and educational pathways to enter the job market, and money management courses.

– Career fairs that highlight job and vocational opportunities.

– Volunteer, apprenticeship and paid job opportunities (appropriate to the levels of the students) to expose them to the world of work. Employment opportunities should not, however, infringe upon the major educational goals of the student.

These types of educational experiences can assist young people to develop employment options and to examine the relationship between their education and their future work.

Implementing Employment Programs

The convener group proposed the following activities to help communities develop and implement employment programs for youth. The key players are policymakers, program managers, and funders.

Policymakers can:

- Increase career planning and job opportunities available to both males and females.
- Provide adolescents with alternative educational routes (e.g., a vocational diploma as an alternative to a traditional high school diploma). Improve the overall status and impact of vocational education.
- Expand opportunities to reach dropouts, and provide them with alternative ways to earn a high school diploma.

Provide incentives, such as financial rewards for successful academic performance.

- Remove financial barriers to a college education for high school students to increase educational motivation.
- Increase the salary base for young people so that minimum wage does not mean poverty level salaries. The minimum wage should be raised to $5.00 by 1992 in order to provide a better economic base for youth.
- Develop youth employment programs that respond to the documented special needs of young women, particularly those from diverse cultural backgrounds.

Program managers can:

- Increase the number of vocational training and job opportunities for youths, which may include revamping high school vocational training to on-the-job training. Some students may benefit from adult education programs while still enrolled in high school.
- Develop work-study programs that encourage career orientation and skills. Begin career awareness programs in elementary or middle schools. Combined with visits to professionals, these will provide young students with concrete experiences of varied occupational options.
- Develop and incorporate a K-12 career curriculum that exposes students to the world of work and promotes pride in working. This curriculum or other educational opportunities, such as a career options course, should be required in high school.
- Provide young people with training in job seeking, improving interview skills, developing resumes and understanding employers' expectations.
- Set up "employer banks" of individuals willing to discuss their careers with young people (e.g., required skills and preparation, salary, benefits, etc.).
- Institute a buddy system or support groups for job hunting for young people.

Life-option role model programs are more general in nature and may not deal with the subject of adolescent sexuality at all.

- Provide incentives, such as financial rewards for successful academic performance. Offer tuition scholarships that can be applied to college or vocational programs.
- Provide counseling services that can help youth explore nontraditional job opportunities.
- Implement programs that place students in jobs in the community for which they may earn either school credit or pay.
- Incorporate more career counseling and career days, as well as job fairs and job "shadowing," wherein young people spend a day with people working in careers they would like to pursue.
- Evaluate whether schools practice sexual stereotyping, and work toward changing these policies, particularly through gender equity programs.
- Incorporate remedial education and educational enrichment in summer job programs to prevent summer learning loss.
- Provide age-appropriate programs in career awareness, job readiness and employment skills training, beginning in elementary school and continuing through high school. Community-based organizations, agencies and businesses can play a key role in the development of these programs.
- Develop special programs to reach out-of-school youth.

Funders can:

- Provide incentives for employers to target adolescents. Subsidize private industry (e.g., by providing tax incentives) to train and provide jobs for adolescents. These could include apprentice programs combined with educational and academic programs or independent and evening study and part-time internships in the private and public sectors.
- Establish special partnerships between industry and government to target particular groups of youths.
- Develop part-time and temporary positions for students, so they can understand the economic advantages and value of staying in school. Support high school vocational education with direct job placement. Jobs, even those that are low-paying, should provide adequate benefits and opportunities for workers to develop additional skills for promotion.
- Expand adolescent training components in currently available state and federal job training programs.
- Provide technical assistance to local communities interested in developing special programs to reach at-risk youths.
- Develop mentor and role model programs connecting local industry and schools. Encourage the school's graduates to return and discuss

their careers and jobs.

- Develop public/private partnerships that guarantee summer and permanent jobs to students who remain in and graduate from high school.
- Work in close partnerships with schools to accomplish all of the above strategies, including exposing at-risk kids to potential job opportunities.

Develop Role Model Programs for High-Risk Youth

The NRC panel recommends that programs providing positive role models for high-risk youth should be developed, implemented and evaluated.

All children need a vision and hope of a productive and self-sufficient future and the chance to develop the skills necessary to attain their potential. The basic needs of children include shelter, nutrition, physical and mental health and meaningful activity. Quality education, childcare, extracurricular cultural and recreational activities, job training and employment opportunities must also be available for youths if they are to identify and validate their special capabilities and build their self-esteem.

Schools should provide students with experiences that prepare them to deal effectively with life. Counselors and teachers need to challenge young people to succeed. Staff need support and training to work effectively with youths. Young people need classes that challenge them, job opportunities that provide educational experiences while still in school and meaningful extracurricular activities that are community-based, culturally appropriate, neighborhood-centered and accessible.

These programs need well-trained staff and stable funding. Existing programs and facilities (e.g., religious organizations, sports facilities, clubs, business and industry) must provide such opportunities. These are all potential channels for developing and providing positive role models for young people.

Unlike role model programs explicitly aimed at helping young people delay the onset of sexual activity, life option role model programs are more general in nature and may not deal with the subject of adolescent sexuality at all. These programs provide extensive outreach into the community to recruit both the potential role model and the young person. Volunteers for role model programs are often recruited from contacts with businesses, professional associations and churches.

Adolescents are recruited through a variety of community settings, including schools, clinics, youth recreation sites and social service agencies. Referrals into programs can come from concerned adults who already work with a young person and who recognize the need for additional support. The success of the match lies in the ability of the volunteer to understand, inspire and relate to the adolescent. While it is preferable that role models closely match the cultural background and personal experiences of the adolescent, it is not always necessary.

Many youth experience poverty, racism and sexism—all of which create the sense that real opportunities for young people do not exist.

Successful role model programs provide individualized training and support to volunteers, depending on the particular needs of the adolescent. Support staffs are also available to answer questions on sensitive issues as well as to step in when an issue becomes especially serious and difficult to handle (e.g., child abuse, violence, etc.).

Some communities have been able to develop some of these strategies, but these efforts occur in only a few places and rarely meet the needs of all eligible clients within a community. Many of these efforts are demonstration projects, with limited stable funding. Additional mentoring and role model programs are needed.

Implementing Role Model Programs

The convener group suggests the following activities to help communities develop and

implement programs that provide positive role models for at-risk youth. The key players are policymakers and funders as well as program managers.

Policymakers and funders can:

• Work in partnerships with youth agencies, schools, adult service organizations and businesses to recruit, train, retain and coordinate the efforts of adult role models. Training should specifically include skill development in working with high-risk youth.

• Develop incentives for community organizations to participate in youth guidance programs.

• Develop and widely disseminate materials that present the negative educational and life experiences of high-risk youth to community leaders, other decision makers and the media to increase recognition of the special needs of this population.

• Establish ongoing financial support and stability for mentoring programs, including adequate monitoring of effort.

• Develop a funding base to provide training in mentoring and role model programs and develop appropriate materials.

Many agencies appear to have a built-in resistance to change and collaboration with other agencies....

Program managers can:

• Expand role model programs, particularly with 1-to-1 interventions, where an adult takes responsibility for assisting a specific child with problems at school and at home. Programs may vary from mentoring and Big Brother/Big Sister relationships to special programs in schools that help connect adolescents with adults who provide them with guidance and support.

• Pay special attention to social/environmental needs of high-risk youth. Be aware of family problems, housing needs, medical concerns, cultural activities and recreation. Use this information in the formulation of programs and in recruiting role models to work with these youth.

Barriers to Implementation

A number of social and community barriers exist that may prevent the implementation of efforts to improve life options for young people. In general, there appears to be a limited level of concern, prioritizing and commitment to expand the life options of adolescents at the community, local and national levels.

Society has not demonstrated the ability to produce tangible, short-term rewards for many disadvantaged youth. There is little motivation to postpone parenthood when a youngster has nothing much to lose by becoming a parent. Many youth experience poverty, racism and sexism—all of which create the sense that real opportunities for young people do not exist. Along with the too attractive drug subculture that flourishes in many low income communities, adolescents face a number of uphill battles. For many youth, the world of work appears to be a distant reality. Schools fail to provide youth with the opportunity to begin career and occupational (vocational) education early enough in their development. The demands on the American family and the lack of stability for many young people have also created additional demands on schools to play the role of surrogate families. This is often done with inadequate support for schools and inadequately prepared staff.

Lack of funding is a major barrier, both at the national and local levels. Despite the increase in national attention on teen pregnancy and youth employment issues, limited funding is earmarked for direct services, research and policy analysis development in the area of improving life options. On the local level, there is increased competition for service dollars between youth agencies and services for other

constituencies such as the elderly and the homeless.

At the community agency level, there appears to be some unwillingness to move beyond agency roles toward a more comprehensive approach to meeting youth needs. Perhaps the concern is that an extensive planning process might reveal duplication of effort or identify agencies that are ineffective, including inadequate schools. The planning to implement comprehensive approaches aimed at improving life options would be extensive and would require the investment of time and financial resources. These planning activities are rarely rewarded or adequately supported with sufficient staff and technical assistance.

Many agencies appear to have a built-in resistance to change and collaboration with other agencies, even when they work with the same target population. Because of the categorical approach in funding and regulations, agencies are often defeated from developing jointly funded efforts. In addition, agencies that initiate collaborative efforts are often fearful that comprehensive approaches may result in their own components being overlooked. For example, the more comprehensive the program, the greater the fear that less attention will be devoted to sexuality issues.

Overcoming Barriers

A number of powerful strategies can help overcome these barriers. However, many reflect major societal problems that can only be addressed, not solved, through even the best intervention programs.

There is a tremendous need to conduct an extensive and careful planning process and to use the results of this planning process and needs assessment data to overcome personality or organizational/territorial issues. Top decision makers (e.g., mayors, school superintendents, etc.) must be involved in the planning as well as the implementation phase. This requires effective communication from top to bottom (and bottom to top) to ensure that everyone understands goals of community process.

Case management is one important program component that young people need to access available resources. In this model, a trained professional works closely with individual clients to access care in a number of agencies without being hampered by agency requirements. By crossing agency lines, many clients can receive a comprehensive array of services.

Another approach is to make local, state and national funding contingent upon demonstrated coordination of efforts between agencies. Collaborative and multiservice models can be instituted to improve the life options of young people. An additional strategy is to tie life options to other school dropout prevention strategies to extend the focus beyond adolescent pregnancy prevention. This approach also encourages greater involvement by young males. Throughout these efforts it is important to determine which messages and rewards work best with high-risk youth.

Parents, guardians and school educators are important allies who are often overlooked. All need to be better informed about the life options concept, so they can recognize how improving life options may help their youngsters. This education should occur within the context of the community and be organized around issues of concern within that community. Adolescents and their families should also be involved in the planning process to identify and develop the alternatives needed to improve their life options. There should also be a renewed focus on systemic (policy) change.

As adequate funding is an important facilitator in helping communities develop alternatives, community foundations and United Way, as well as national funding agencies, should be well versed in the parameters of life options for young people. ❑

Summary

We hope the strategies and action steps included in this document will help communities across the country consider what the next steps will be in their efforts to meet the challenge of preventing adolescent pregnancy and to meet the complex needs of young people in general. Because a clustering of risk behaviors often occurs during adolescence, efforts at pregnancy prevention can be seen as part of a multipronged effort. We need to learn more about what works in these efforts, but there is sufficient knowledge for communities to proceed to develop their own programs and to replicate and adapt the programs of others around the country.

At the core of these programs, and in whatever variation or hybrid they may emerge, key factors in successful programs will most likely include: (1) early intervention, whether it is in the area of education, counseling or health care; (2) accessibility and acceptability, including programs that are physically accessible, affordable, culturally sensitive and psychologically acceptable to teenagers; (3) continuity of services over an extended period of time, so progress can be sustained; (4) targeting of strategies to meet the varying needs of young people, which are affected by their developmental stage, their gender, socioeconomic and cultural background; (5) multipronged and integrated approaches that incorporate a variety of concurrent strategies within a comprehensive community-wide plan; and (6) broad-based commitment from major community institutions, including families, school districts, health care providers, community groups, government, private agencies and adolescents themselves.

The strategies in this document reflect an ongoing evolution in the field of adolescent pregnancy prevention. The lessons learned create the basis for the next generation of programmatic effort. Some of the suggestions may already be in place and well established. Others may represent a brand new effort for communities.

We encourage communities to review what is already in place, how well those efforts are meeting the needs of youth in the community and what additional efforts can build on the initial effort. For example, if local businesses are already contributing funds to the school system, you many wish to explore what other activities, such as career development and mentoring programs, can be developed and sponsored by that sector. In many respects, we see these efforts as building blocks, upon which communities across the country create the approaches that respond to the needs of young people and enable them to delay too early childbearing.

We encourage you to use these strategies as a starting place. Some strategies can be used as is, while others will spark other ideas that will fit your community better. We encourage you to engage in collaborative community planning to make many of these strategies a reality for young people. ❑

Resource Directory

Many national and regional organizations and groups are committed to developing and implementing adolescent pregnancy prevention strategies. Before you initiate your community effort, or as part of your ongoing efforts, we encourage you to review the following resource list. The organizations reflect a full range of groups, from community-based youth development programs to research and policy organizations. Together, they can provide you with a wealth of information and technical assistance in developing or enhancing your current efforts and guidance as your community considers its next steps.

Academy for Educational Development
100 Fifth Avenue
New York, NY 10010
(212) 243-1110

The Alan Guttmacher Institute
2010 Massachusetts Avenue NW
Washington, DC 20036
(202) 296-4012

American Association of School Administrators
1801 N. Moore Street
Arlington, VA 22209
(703) 528-0700

American Civil Liberties Union (ACLU)
132 W. 43rd Street
New York, NY 10036
(212) 944-9800

Association of Junior Leagues International, Inc.
660 First Avenue
New York, NY 10016
(212) 683-1515

Carnegie Council on Adolescent Development
2400 N Street NE, 6th Floor
Washington, DC 20037
(202) 429-7979

Catholic Charities U.S.A.
1319 F Street NW
Washington, DC 20004
(202) 639-8400

Center for Early Adolescence
Suite 223, Carr Mill Mall
Carrboro, NC 27510
(919) 966-1148

Center for Population Options
1025 Vermont Ave. NW, Suite 210
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